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ABSTRACT

In response to the growing need to provide health and social services to rural America, the conference addressed the political, economic, and social issues involved in providing appropriate health and social services to rural residents. A cadre of individuals from various disciplines presented alternatives and solutions to these issues. This document presents the proceedings of the conference, the issues addressed, and some of the major speeches given. Some of the papers deal with strategies of other countries in improving medical resources, the identification of the specific medical problems and needs of a rural community, and government financing of rural health care. Another paper gives the perspective of a rural resident on social welfare consumers, policymakers, and providers. Other papers deal with community development and health care, a case study of human service delivery in rural Tennessee, and rural community development as seen by a person who has served both as a rural county agricultural agent and a community action leader and director. In the paper titled "Reviewer's Notes", the contributions of a panel discussion on rural community organization and development are summarized and the inputs synthesized into a systems model. The final three paper present social service models, health service models, and a discussion on policy making and funding. (DS)

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Models of Rural Social
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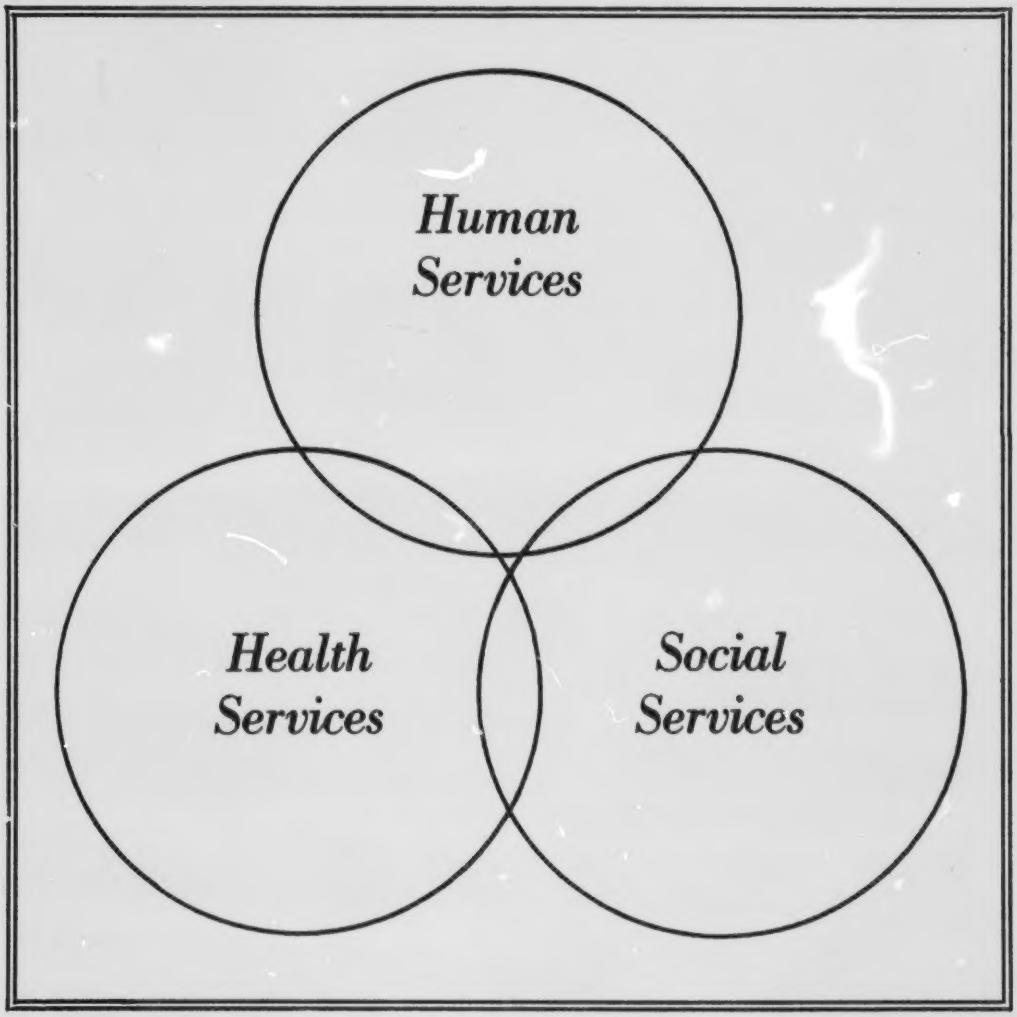

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MODELS OF RURAL SOCIAL AND HEALTH SERVICES

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TENNESSEE STATE UNIVERSITY
Human Service Needs Research Project
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NASHVILLE, TENNESSEE

PAPERS PRESENTED AT

The First National Conference on

SIMULATED MODELS OF RURAL SOCIAL AND HEALTH DELIVERY OF SERVICES

OCTOBER 19-20, 1977
HYATT REGENCY, NASHVILLE, TENNESSEE

THE HUMAN SERVICE NEEDS RESEARCH PROJECT
Department of Social Welfare
TENNESSEE STATE UNIVERSITY

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Foreword

The first national conference on rural social and health delivery of services was held October 19-20, 1977, at the Hyatt Regency, Nashville. The conference attracted approximately 120 individuals from all parts of the country.

The National Conference on Simulated Models of Rural Social and Health Delivery of Services was in response to the growing need to provide appropriate health and social services to rural America. This conference addressed the many issues involved in providing appropriate health and social services to rural residents that is, political, economic, and social issues. The conference utilized a cadre of individuals from various disciplines to present alternatives and solutions to these issues.

The proceedings of the conference have been compiled for the benefit of the registrants and other individuals interested in rural social and health delivery of services. Presented here are the issues addressed and some of the major speeches given.

PREFACE

In 1975, the Department of Social Welfare at Tennessee State University was awarded a two year research grant from the United States Department of Agriculture to study the "Human Service Needs of People Living in Selected Isolated Rural Areas in or Near Metropolitan-Davidson County, Tennessee."

The objectives of the research project were:

(1) To gather data on the social and health needs and characteristics of people living in selected isolated rural areas, in or near Metropolitan Nashville and Davidson County.

(2) To gather data on the resources and services available to and utilized by the people in these areas for meeting these needs.

(3) To evaluate the adequacy and effectiveness of these resources and services in meeting these needs.

(4) To identify specific gaps and shortcomings in resources and services.

(5) To make recommendations for developing a model for a service delivery system to meet human needs in these and similar rural areas.

The research project was conducted in three phases. The first phase included obtaining and compiling existing data on the communities selected. The second phase consisted of interviews with representatives for purposes of gathering data on the availability and utilization of services in rural areas. The third phase consisted of a household survey in each of the communities. The residents were interviewed to determine specific problems, gaps, and shortcomings in existing programs.

This conference was a by-product of the research efforts of the Human Service Needs Staff and Advisory Committee. It was designed to share with the participants some of the issues of national importance in meeting the health and social service needs of rural america. Of primary concern was the identification of steps in developing models of service delivery and its appropriate application. Prominent educators, health and social service practitioners, and governmental officials served as valuable resources in addressing some of the issues.

In additon to generating a research report, the results of the study will be disseminated directly to private and public agencies involved in program planning and development. This information may be used by planning agencies for purposes of taking action to assist in coordinating services, identifying and mobilizing existing resources, and developing new resources and services to meet the needs of the residents of these areas.

ACKNOWLEDGEMENTS

The success of the First National Conference on Simulated Models of Rural, Health and Social Services was due to an enormous amount of time, effort, and early planning by members of the Human Service Needs Advisory Council and Staff. The creative input of Lettie Galloway, Leslie Falk, Lucille Dean, Alma Pillow, John Corry, Donald Watson, Keith Fiscus, Robert Pasley and James Reeves, is gratefully acknowledged. In addition to the input of staff and members of the advisory council a special debt of gratitude is due to the faculty, staff, and student body of the Department of Social Welfare, at Tennessee State University and Meharry Medical College for their support. Special thanks goes to the conference hosts and hostesses.

The conference was funded by the Human Service Needs Research Project, The Public Services Center, both of Tennessee State University, and fees paid by participants--the last two groups to whom thanks are offered. The enthusiasm, interest, and expertise of the participants, the workshop leaders, and the conference reviewers provided for a successful conference.

The editors wish to express their gratitude to Jo Helen Railsback and Frances Hempstead for invaluable editorial assistance in the preparation of this volume, and to Deitra Wade and Stella Mastin for editorial typing.

PURPOSE

By:
Joylean P. Sampson, M. S.W.
Principal Investigator, Human Service Needs Research Project
Tennessee State University

The sponsors of this conference, Human Service Needs Research Staff, and Advisory Council along with the Public Service Center, proudly welcome you to the "First National Conference on Simulated Models of Rural, Social and Health Delivery of Services."

In 1975, the Department of Social Welfare at Tennessee State University was awarded a two year research grant from the United States Department of Agriculture, Cooperative State Research Services, to study the "Human Service Needs of People Living in Selected Isolated Rural Areas in or Near Metropolitan-Davidson County, Tennessee." Shortly after the research staff and advisory committee were selected and the research process began, we realized the magnitude and the nature of the research upon which we were about to embark.

First, this was an opportunity to review the present social and health service systems in isolated areas of rural Tennessee, specifically to determine agency effectiveness, to assess community and family needs. The implications of a study of this nature would tend to imply the need to develop models of delivery of social and health services for rural areas of Tennessee. What better way of understanding the rudiments of the delivery of services than through the development of a national conference on simulated models, and so, here we are.

Simulation is a technique that has come to be used quite extensively in the social sciences. Simulation models are attempts to specify the parameters or boundary characteristics of some social system-in our case, health and social services. This involves modeling the system and specifying the variables which constitute the model of the phenomena, suggesting links among variables. It is believed that some of the content issues of this conference suggest links in the models, if not variables, for example:

1. The identification of some of the health and social problems in rural America:

2. The role of community organization and development in simulation models:

3. The impact of policy making and funding in delivering services to rural areas.

Simulation models can be thought to be three types: all computer all people, and mixed people and computer (Meier, 1965). Needless to say, the simulation model this conference and its participants are identifying with is the "all-people" simulation. While there will be no role playing or gaming as such, we are attempting to set some boundaries as they relate to health and social services in the rural setting.

These boundaries may serve to define the problems of an environment (community), the kinds of behavior required, and the decisions required to effectively set in motion a delivery system that would work. Further, this conference will serve as a means of sharing information on "how to" develop models and the practical application thereof. Even though simulation models serve to simplify phenomena by reducing the number of variables, we do not want to forget the "real environment" or the "real world" situation.

Simulation models of organizations, agencies, schools, businesses, governments, etc. are means of representing real phenomena in a single, observable, and less costly manner. Thereby, a conference of this nature may serve to enlighten researchers, educators, health and social service practitioners, consumers, and participants about the structure and function of the rural social and health delivery systems that are being modeled. And, given a sufficiently accurate simulation, the simulation environment may serve as a rich and detailed experiment permitting appropriate application.

IMPROVING RURAL MEDICAL RESOURCES: STRATEGIES OF OTHER COUNTRIES

By:

Milton I. Roemer, M.D.
Professor, Public Health, UCLA, Los Angeles, CA

I am honored to be invited as a speaker in this conference on "Rural Delivery of Social and Health Services."

Rural health care handicaps are world-wide. Every country, from the poorest to the richest, suffers from fewer resources--in health personnel and facilities--in rural areas.

For some years, I have been studying the health care systems of other countries, and in the last four years I have had the opportunity to study five countries in some depth, examining problems of health manpower, including their geographic distribution. I hope you may find it of interest to hear what certain other countries are doing to improve the supply of rural doctors, and I hope that this may add some special perspective to your discussion of U.S. problems in this conference.

United States Efforts

The United States has, of course, also given much attention to this problem of rural health resources. To mention some of the main efforts:

(1) After long delay, we have (in about the last 10 years) increased the total national supply of doctors in relation to population. This inevitably helps rural areas to some extent, even though the great majority of new graduates settle in the cities.

(2) Many rural communities have long offered inducements to attract doctors. Here in Tennessee, there has been an active program to provide attractive medical offices in rural towns

since 1953. Legislation, authorizing small towns to guarantee doctors minimum incomes, was passed in the New England states in the 1920's.

(3) State governments have been giving fellowship loans to medical students since 1945, with each year's loan being forgiven by practice for one year in a rural area of need.

(4) Group medical practice (strange as it may seem) has been more highly developed in rural states and rural regions than in urban centers. This has helped to bring specialists to rural populations, specialists who could not make a living in a small town if they were in solo practice.

(5) Substantial improvement in rural hospitals, the supply of rural hospital beds, has probably been a major influence--thanks to the policy of priorities for underserved areas under the federal Hill-Burton construction program--in holding doctors in rural districts.

In few fields, in fact, have we been such improvements achieved as in the national distribution of hospital beds over the last 30 years. Just to give a few figures:

	Hospital beds per 1,000	
	1942	1972
10 most urban states	4.2	3.9
10 most rural states	2.3	3.7

(These are approximations, but they demonstrate the great rural improvements.)

In spite of these efforts (and there have been others, like building medical schools in rural states, the RMP program, etc.), the rural supply of doctors, relative to urban, has stayed about the same. It is difficult to get exact data (because of the changing definitions of "rurality"), but there may have been a slight improvement in the doctor-supply in "non-metropolitan" counties, since 1950.

Perhaps we can say that, if it had not been for the special efforts that I summarized, the rural handicaps would have become much worse.

Still in 1973, the ratios of doctors in the U.S. were these:

Type of County (Population)	Population per doctor in the county
5,000,000 or more	511
1,000,000 to 5,000,000	623
500,000 to 1,000,000	747
50,000 to 500,000	835
"Potential metropolitan"	1,095
Non-Metro, 50,000 or more	1,100
25,000 to 50,000	1,432
10,000 to 25,000	2,030
Less than 10,000	2,512

Still, the rate of health services received by rural people has improved over the years. In the 1928-31 period (C.C.M.C.) residents of large cities (100,000 pop. and over) saw doctors about twice as frequently as residents of rural counties.

Since then, the utilization rate for doctor's care has risen for both urban and rural people--for many reasons--but, it is especially interesting that the differential has been reduced. In 1973-74, the contacts with doctors were:

	Doctor contacts/person/year
Metropolitan areas	5.2
Non-metropolitan areas	4.5

Those rates are almost equalized--much more so than the supply of doctors. The main reason, I think, has been improved transportation mainly. For hospitalization, in fact:

	Admission per 1000 per year
Metropolitan areas	131.0
Non-Metropolitan areas	161.4

This may mean that the doctor serving rural people (wherever he is located) saves his time (on home calls) or the patient's time, by hospitalizing cases more often. So, we pay the price of inadequate supplies of doctors in rural areas by more use of hospitals (which are very costly).

Therefore, despite the improvements in rural health services, there are still real deficiencies in the availability of doctors nearby.

We can now consider the findings of our study of what other countries (all relatively affluent, like ours) have done about this basic problem, mentioned at the outset. The countries studied all have national health care systems, which put an obligation on their governments to see that care is available to people, wherever they live.

Introduction and Methodology: International Study

The countries studied were Australia, Belgium, Canada, Norway, and Poland. These five were selected to illustrate a range of different types of national health care systems insofar as such systems would obviously have an important bearing on health manpower policies. The first four of the countries (alphabetically) have systems of national health insurance covering all or nearly all of the population; the scope of benefits and methods of administration, however, differ in many features. The fifth country, Poland, operates a "national health service," in which financial support is derived almost entirely from general revenues of the economy, and all resources (both personnel and facilities) are controlled directly by the government. Perhaps the principal common attribute of all five health care systems is that the great majority of health services in the nation are financed collectively and provided as public benefits to the whole population.

Four of the countries are parliamentary democracies, of which two (Belgium and Norway) have constitutional monarchies. Two are federations of states or provinces (Australia and Canada), in which there are many differences among the component jurisdictions regarding health policies. In the constitutional monarchies there are also provinces or countries, but in the main they carry out policies that are determined by the central government. Poland is a socialist country, where general control is exercised by the dominant political party.

For all five countries, a literature search was conducted (through the MEDLARS system) on health manpower articles published over approximately the previous ten years. Field visits of 5-10 weeks were then made to each of the countries during the years 1973-1976. Interviews--focused on eliciting information regarding health manpower policies, practices, and experiences--were held with executives of the ministries of health, social security authorities, provincial and local public health agencies, universities and other training institutions, professional associations, consumer organizations, hospitals, and other health facilities, regulatory agencies, important voluntary health bodies, individual providers and recipients of health service, and miscellaneous other knowledgeable persons involved in the health service field. In all interviews, information was sought on health manpower education,functions, and regulation, with special attention to policies and practices regarded as "innovative," insofar as they differed from the conventional methods of our own country, the United States of America. Numerous official reports and unpublished documents were collected, wherever possible, particularly to obtain quantitative data on health manpower supplies, distribution, and trends.

On the basis of the information gathered in these ways, a monograph was prepared on each of the five countries. Each country's monograph presents the findings under six main headings: (2) the national health care system, (b) innovative functions of health personnel, (c) health manpower resources, (d) health manpower education, (e) regulation of health personnel, and (f) salient highlights, issues, and trends. As part of the second general topic--health manpower resources--data were presented on the geographic distribution of physicians, dentists, nurses, and other major categories of health personnel, along with accounts of the efforts being put forth to equalize this distribution in relation to population needs.

In all five countries studied--as in virtually all nations of the world--there were found to be inequalities in the distribution of physicians and other health personnel between cities and rural areas. The natural flow of people and health services in geographic regions, of course, inevitably requires greater technical resources in the cities, but the degree of such urban concentration is usually excessive. To cope with the resultant under-supply of health manpower in rural districts, numerous actions have been taken specifically to strengthen rural resources.

Before discussing these rural-specific efforts, we should take note of several underlying features of national health policy in the study countries, that indirectly must influence the availability and distribution of all health services--urban and rural.

Underlying Influences

The rural impacts of many aspects of the national health care systems as a whole should not be overlooked, simply because they are not identified as having specific "rural" objectives. Most fundamental is doubtless the operations of national systems of health insurance in four of the countries and a general tax-supported system covering everyone in Poland. These economic support programs mean, of course, that the typically lower income levels in rural districts do not directly discourage rural settlement of physicians and dentists, as they do in the United States. This basic point should not be exaggerated since, even with financial protection, rural people for many other reasons do not tend to seek as much medical care as urban. Under insurance programs paying doctors by the fee-for-service method , therefore, rural practitioners still tend to earn lesser incomes. Moreover, co-payment requirements in Norway, Belgium, and Australia may offer some financial deterrence to low income families--commoner in rural areas. Nevertheless, the protection of social financing doubtless reduces one of the handicaps of rural settlement of medical manpower.

Secondly, the general national enlargement of the health manpower supply, which has occurred in all five countries, undoubtedly affects the numbers available for rural service. With shortages of physicians or other health personnel, the more attractive urban locales for work and life are bound to be occupied first. Even in the most free market economies, however when urban opportunities for doctors are saturated, rural locations will be sought; thus, a larger over-all supply of health personnel is bound to help the rural areas. Obviously, many factors influence the point of "saturation" of a medical market, but the steady expansion of the supply of physicians and nurses in all the study countries, and also of dentists in Norway and Poland, has clearly benefited rural areas.

Thirdly, a national system of health care delivery that is basically orgainized, as in Poland, helps to assure personnel at all locations, urban and rural. In Poland, where all physicians and dentists must work seven hours per day in the systematized public program, the availability of vacancies on the "organization chart" is crucial. While Polish physicians are not "ordered" to go to one place or another, they will naturally go where positions are available; if all urban posts are filled, they must take a rural post. This strategy has, indeed, operated to steadily improve rural health care resources in Poland.

Similar dynamics operate within the hospital services of Norway and to a lesser extent in Australia. When the medical staffs in hospitals are entirely (as in Norway) or substantially (as in Australia) composed of salaried specialists, the physicians trained in various specialties must go essentially where hospital posts are available; the specialist may also engage in private practice outside the hospital, but membership on the "closed staff" of a hospital is a practical necessity. Thus, the establishment of hospitals in the rural regions of Norway and Australia, as well as in Poland, inevitably attracts health personnel.

Fourthly, implementation of the concept of regionalization of health facilities is especially helpful to rural people. To some extent, this policy is being applied in all five study-countries. In Poland, the establishment of virtually all hospitals, health centers, and health stations is in accordance with a centrally planned regional scheme. This is also the general strategy for hospital construction in Canada, Norway, and Belgium through the selective awarding of capital grants. To a lesser extent, it is applied toward the construction of health centers for ambulatory care in Australia and Canada. With the organization of regional public health authorities in Canada and Australia, moreover, the operation of citizen boards may offer a stronger voice for articulating rural personnel needs.

A fifth broad national policy with special rural implications is the movement in all five countries to strengthen general medical practice. The ways that this is being done are too numerous to review here, but it may be noted that the generalist in medicine has a manifestly greater role to play in rural areas. In all five countries the swing of the pendulum toward specialization has been slowed down or reversed in recent years. Specialization is bound to be more concentrated in urban centers, but the principal need of rural people is for general primary care, after which they may be referred elsewhere for needed specialty services. The newer type of "specialist in general medicine" has a role, par excellence, in rural communities.

Finally, a sixth general policy with special dividends for underserved rural localities is the operation of information systems for doctors and others seeking a place to practice or work. The Norwegian Medical Association provides such an information service for all new medical graduates; provincial medical associations in Canada and state associations in Australia likewise maintain data on communities needing doctors. In Australia, the national medical association assists small town doctors in finding locum tenens replacements, to permit them to take a holiday.

Special Strategies for Rural Health Services

More specifically directed toward equalizing the geographic distribution of health personnel in the five study-countries, numerous other strategies were identified.

Two years of mandatory service in a rural post, after completing medical school, were required in Poland from 1948 to 1963. This requirement was ended when Poland had achieved a large enough overall supply of doctors to rely instead on voluntary incentives. In Norway, a similar period of mandatory rural service had perviously been required of new medical graduates, and also abandoned a few years ago when the supply of doctors had expanded enough. Of the 18 months of supervised post-medical school training required of all Norwegian graduates, six months must still be spent as assistant to a District Doctor (whose role is also discussed later).

In Canada, recent actions have been taken to limit the immigration of foreign physicians. Some provinces, however, grant licenses to immigrant doctors only for practice in underserved rural communities; this restriction applies until citizenship is gained, which usually requires five years. A sort of "reverse compulsion" is applied in the Canadian province of Quebec; here certain cities are declared "over-doctored" for purposes of payment under the medical care insurance program. Thus a physician is, in effect, compelled to settle and practice in a community needing more doctors if he expects to be paid by the insurance system. Smaller towns in rural districts would naturally benefit from this policy.

Much more widely applied in all five study-countries are several specific inducements to attract doctors voluntarily to rural locations. In Canada, with its extensive rural stretches, various policies have been implemented. Even before the national medical care insurance program (1967), many rural municipalities in the prairie provinces (particularly Saskatchewan) offered public salaries to attract general practitioners--the first of these being started in 1914. Later provincial governments gave supplemental grants to these "municipal doctor plans." More recently, the province of Ontario has guaranteed relatively high annual incomes to doctors who settle for a stated period in certain rural localities; the local community assumes responsibility for adequate housing and office facilities. The great majority of doctors entering this program have, in fact, remained in the rural community beyond their initial contract period. Some Australian states have likewise guaranteed doctors minimum incomes for settlement in small towns.

In Poland, as noted, there is no longer any mandatory period of rural service, in spite of the generally structured character of the socialist health care system. Rural medical and dental posts, however, offer higher salaries than positions with similar responsibilities in a city. More attractive housing is offered than is likely to be available in a city, where--in light of the rapid Polish urbanization--housing is still in short supply. The rural doctor also can purchase an automobile, on more favorable terms, than his urban counterpart. Automobile expenses are paid, of course, for professional travel.

In reference to traveling expenses, the social insurance systems of all countries reimburse the doctor for these costs incurred making home calls to patients. In Belgium, the doctor making a long drive to a rural patient is reimbursed for the time of this travel, as well as the motor vehicle expenses.

The District Doctor system of Norway is one of the most impressive strategies for getting health care protection to rural populations. The national government appoints and pays the physician a basic salary for taking public health responsibilities in his area. Most of the doctor's time, however, is spent in general clinical service to the local population, for which payment is made by the insurance system. The entire country is covered by some 600 District Doctors, each of whom is assisted by one or more public health nurses and sometimes a sanitary inspector. Most of the districts are quite thinly settled, and in Norway's far north, the positions offer longer holidays, subsidized housing, and supplemental credits toward later attainment of specialty status if desired. The Norwegian District Doctor soon finds himself a much respected leader in general community affairs; the whole system, with its national status, has a rich tradition that engenders a strong esprit de corps. There are virtually no vacancies in the 600 positions throughout the country. For the U.S. population of more than 200,000,000 this would be equivalent to over 30,000 primary care doctors (compared to less than 1,000 in the U.S. Health Service Corps developed to help underserved areas).

On a more limited basis, some Australian states have appointed salaried rural doctors, who served patients without charge during certain hours each day, and for fees at other hours. These salaries were paid partly by the state government and partly by the local community.[4] Since the 1974 social insurance legislation, governmental stipends are simply supplemental to the doctor's health insurance earnings.

Both Australia and Canada have long used the device of fellowships for medical or dental schooling, in return for equivalent periods of later service in rural communities. This approach has been particularly successful in Ontario. In the other three countries, where almost all professional school students in financial need are supported by national stipends, such a mechanism would have little meaning. Medical schools in Canada and Australia also send students for brief periods of training in certain isolated communities.

Organized airplane transportation is a special strategy for providing medical care to very isolated patients in some countries. Australia has its "flying doctor service," to bring physicians to the vast thinly settled interior. Several Canadian provinces have special "airplane ambulance" systems, which bring remote rural patients to the larger city hospitals any time of the day or night; telegraph or radio communication is part of this process. These programs are all subsidized by government.

Finally, in very thinly settled regions of Canada's far north and the Australian "outback," there are health stations staffed by nurses with extended roles. The substantial responsibility and dramatic overtones of these posts make them attractive to a certain type of woman, and there are few vacancies. These positions are typically financed by government and supervised by a territorial physician, but the nurse does much diagnosis and treatment on her own; she seeks medical help by radio or refers the patient to a distant facility only in difficult conditions. With very few exceptions, this type of broad responsibility is not delegated to nurses in rural villages within an hour or two of travel time from a city, nor is it found in any of the European countries studied.

Other strategies affecting the geographic distribution of health manpower may be briefly noted. Dental care programs for children in rural areas are well developed in Norway, through governmental support of dental clinics. Some Canadian provinces send "dental nurses," trained and authorized to provide virtually complete dental care for children, to work in rural schools. Australia, in some states, gives priority to serving the dental needs of rural children. The public (governmental) control over the location of private pharmacies in both Norway and Belgium--and of the public pharmacies in Poland--has the effect of reducing excessive concentration in the cities and equalizing drug services for the rural population. In Norway, rural pharmacies are even subsidized from a fund raised through a special tax on all urban pharmacies.

In summary, the many-faceted national programs for economic support of health care in all five countries studied generate a wide variety of strategies, direct and indirect, to increase the availability of services to rural populations. These strategies are, in a sense, a political necessity associated with nationally financed health care systems; since virtually everyone contributes to the support of the health services, everyone has an obvious right to expect them to be available--wherever he may live. At the same time, the operation of the national health care system offers numerous workable methods to achieve improvements in the geographic distribution of health manpower.

Limited quantitative data to demonstrate these improvements are available from Norway, Poland, and Canada. In all five countries, however, rural health care handicaps do not now appear to constitute the social issue that they are in the United States, which lacks a national health care system. The precise methods employed to minimize this problem clearly depend on the governmental structure and political ideology of each country.

Note: The study on which this paper is based was supported by a research contract of the Health Resources Administration, in the U.S. Department of Health, Education, and Welfare--Nol-MI-34090(P).

These observations on the strategies of five other countries for increasing the availability of doctors to rural people are, I hope, suggestive to us in the United States. We are richer, as a nation, than any of the countries described, and yet our rural health deficiencies are as great or greater. If the basic issues can be clarified, and if the understanding of rural people can be translated into political demands, we can surely apply many sound ideas practiced in other countries, to improve health services for the rural people of the United States.

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(1) One of these monographs has so far been published: Ruth Roemer and Milton I. Roemer, *Health Manpower in the Changing Australian Health Services Scene*, Washington: Health Resources Administration, 1975. The others will all appear in 1978 as: Milton I. Roemer and Ruth Roemer, *Health Manpower under National Health Insurance: the Canadian Experience*; M.I. Roemer and R. Roemer, *Health Manpower Policies in the Belgian Health Care System*; M.I. Roemer and R. Roemer, *Health Manpower in the Socialist Health Care System of Poland*. The summary volume is entitled: M.I. Roemer and R. Roemer, *Health Manpower Policies under Five National Health Care Systems*. All are to be published by the U.S. Health Resources Administration, Washington, D.C. 1978. Data and sources for all the information in this paper will be found in these publications.

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MEDICAL CARE IN RURAL COMMUNITIES: PROBLEM IDENTIFICATION AND ALTERNATIVE SOLUTIONS

By:

Sam Cordes
Department of Agricultural Economics and Rural Sociology
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Countless rural communities sense that the level of medical care available to them is inadequate. In the past seven years my professional responsibilities have led me to become involved with such communities in two states: Washington and Pennsylvania. My remarks this morning will be based upon these professional experiences; as well as upon my own personal experience of being reared 40 miles from the nearest doctor in Western South Dakota.

These professional and personal experiences have led me to conclude that it is very easy for a rural community to choose an inappropriate solution for meeting its medical care problems. Frequently, the reason for an inappropriate choice is because the community has not:

(1) Identified precisely the exact nature of its problem.

(2) Considered the full-range of alternative solutions for the problem at hand.

These two general concerns will be the framework for the rest of my discussion.

PROBLEM IDENTIFICATION

Many times I have asked a community group to tell me about their medical problem and they have replied: "We need a doctor." or "We need a medical clinic." I gently remind them that they have not told me anything about their problem. What they have done instead is to tell me what they believe is the solution. This is obviously getting the cart before the horse, and frequently indicates that the community has not spent enough time accurately identifying and analyzing the exact nature of the problem. In these situations, additional probing usually uncovers a feeling that the community has "inadequate" medical care. In order to gain more precision on this notion of inadequate medical care I usually suggest to the community group that it grapple with two inter-related questions:

1. Why do you feel your community's medical care is inadequate?
2. Why do you want your community to have its medical care needs met more adequately?

Why Do You Feel Your Community's Medical Care is Inadequate?

In grappling with this question, community groups typically answer in one of four ways. I will comment briefly on each answer.

Answer #1: The Incidence of Mortality and Morbidity (disease, illness, disability, etc.) is Excessively High in Our Community - This answer often indicates a belief that medical care will have a significant positive impact on mortality and morbidity. In certain instances certain kinds of medical services can reduce mortality and morbidity. However, in general, research indicates quite clearly that medical care, at best, has no effect or only a negligible positive effect on mortality and morbidity

(13; 25) At worst, it may have a negative impact (7;21;40).

In short, communities wishing to reduce their mortality and morbidity should avoid defining their problem in terms of medical care inadequacy. More often than not the real problem is one of poor nutrition; unsanitary housing, water supplies, and sewage disposal; occupational hazards; air pollution; unsafe highways; and unhealthy personal habits related to exercise and the consumption of drugs and tobacco.

Answer #2: Our Community Used to Have More Medical Services Than It Now Has - This answer implies that the availablity of services in the past is an appropriate norm to be used for the present. There are at least three reasons why this norm may not be appropriate. First, the community may have had too many medical services in the past. Second, the community's need for medical care may have diminished because of such factors as population decline, or because there has been a reduction in the percentage of elderly persons in the community. Third, and perhaps most important, improvements in transportation may have increased the accessibility of medical care in neighboring communities. For example, the rural resident who lives 30 miles from the nearest doctor today may be much closer (in terms of time) than he or she was 40 years ago when the nearest doctor was only 15 miles away.

Answer #3: On a Per Capita Basis Our Community Does Not Have As Many Medical Services As Other Communities - This answer is usually generated on the basis of comparing the community's per capita supply of medical resources to state or national averages. One of the major problems with such comparisons is that the per capita supply of medical resources is not necessarily a good proxy for the amount of medical services actually produced. For example, rural-urban comparisons of the per capita supply of doctors suffer from the fact that rural physicians see significantly more patients per week than do urban physicians (19, p. 148 and 150).

A second major problem with such comparisons is that no allowance is usually made for differences among communities in their medical care needs. Again, rural-urban comparisons can be used to illustrate this point. On the one hand, it can be argued that rural areas should have more doctors per capita than urban areas because the rural population is generally older, less affluent, less educated, and more frequently engaged in hazardous occupations such as mining, forestry, and farming. On the other hand, it can be argued that urban areas should have more doctors per capita than rural areas because urban areas have more overcrowded housing, greater air pollution, and more violent crimes.

Aside from differences in resources productivity and medical care need, there is an even more serious problem involved in comparing a community's per capita supply of medical resources to a state or national average. This problem stems from the assumption that a state or national average is an appropriate norm. In point of fact, there is no logical base for this assumption, and it may be that the nation or a particular state has too many medical resources per capita. For example, research indicates that an increase in the number of surgical procedures performed (3; 17; 28); and a disproportionately large share of these additional procedures are likely to be unnecessary. This means that a community that has fewer surgeons per capita than the nation or a particular state may be better-off than if it had more surgeons.

Answer #4: There Are People in Our Community Who Are Not Getting Adequate Medical Care - In terms of my own biases and experiences, I find this answer to be the most persuasive insofar as documenting the inadequacy of a community's medical care. However, it is important to determine whether or not this response represents both providers and consumers of medical services.

Consumers believe they are not getting adequate medical care when they seek such care and do not receive it, or when they are dissatisfied with the care they receive. Community surveys designed to measure the experiences and views of the medical consumer have become quite sophisticated, due largely to the execllent work of Aday and Andersen (1). However, results of this kind of community survey will often be disputed by the providers of care (6). Their basic argument is that consumers are not in a good position to judge the adequacy of medical care. For example, providers may argue that some consumers who seek medical care but do not receive it are not truly in need but are suffering from hypocondria. When these kinds of differences in perspective exist it is essential that an attempt be made to try to get the various factions to develop some common notion of how to measure "adequacy". Despite this difficult problem I believe the community survey approach to the adequacy issue is far superior to (1) relying strictly on mortality/morbidity measures or (2) comparing the community's present supply of medical resources to what it had in the past, or to some state or national average. Why Do You Want Your Community To Have Its Medical Care Needs Met More Adequately?

Grappling with this question often provides additional precision in defining community problems related to medical care. The first response to the question is likely to be stated in terms of improving the health status of the community. However, it was noted earlier that in most instances medical care will likely have little positive impact on a community's mortality and morbidity rates. This does not mean that a community is necessarily irrational in wanting its medical care needs met more adequately. What is does mean is that the community views medical care as serving important functions other than "curing."

One of these important functions is "caring." In this regard Fuchs notes that:

> people who are troubled, who are in pain, who are disabled, want to see someone, to talk to someone, to share their troubles with someone. As much as a "cure," they want, sympathy, reassurance, encouragement. They want explanations: "why did this happen?" "How long will it last?" "Should I have any more children? Above all, they want someone who CARES.
>
> Indeed, with the decline of religious beliefs, the breakup of families, the increase in mobility and anonymity in our urban culture, it may well be that the demand for "caring" is greater than ever before (13, p.65).

In addition to the caring function, a community often views medical care in the context of a larger community development strategy. Medical care fits into this larger strategy in at least two ways. First, more adequate edical care may be viewed as a way of attracting new businesses and industry into the community (14; 24). Second, the provision of medical care creates employment for community residents. For example, it is my guess that the local hospital or medical center is the largest single employer in many small rural communities. As another example, a recent study indicates that the rapid growth in jobs in nonmetropolitan areas is being placed by service jobs, and that "much of the credit belongs to strong community action for better medical and health services" (16, p. 20).

A final function served by medical care is what Crawford refers to as the medical-legal function. In discussing this function he notes that it would include the securing of:

> Required physical examinations for employment, school related activities, operation of a motor vehicle, and procurement of life insurance. Also included here are legal requirements for physician coverage at various school sports events. In at least one state, Pennsylvania, the state association regulating school sports event (PIAA) requires a physician to be present at all PIAA sanctioned football games. Some smaller rural communities with high school football teams have found themselves nearly forfeiting a game for lack of physician coverage. I doubt this problem is widespread or viewed as important by health professionals; nevertheless, it is viewed by residents in some communities as a function which the health system must fulfill (8, p. 4).

In summary, the provision of medical care serves a number of functions. A very useful exercise is to have a community group discuss in depth what function(s) they wish to have served for their medical care needs to be met more adequately. This discussion typically leads to added precision in defining their real problems.

ALTERNATIVE SOLUTIONS

The exact nature of a community's medical care problem obviously circumscribes the kinds of solutions which are relevant. Implicit in my earlier remarks was the fact that different communities identify different kinds of problems. For example, a community's medical care problem may really be part of a larger community development problem.

Despite the wide variety of medical care problems faced by different rural communities, my experience has been that the most common problem is one of community residents being unable to receive the care they feel the need. Assuming their perception of their needs is "accurate, " the root cause of this problem is typically lack of either availability or accessibility of services. I shall define the problem of availability as a situation where services are nonexistent or in short supply; and the problem of accessibility as a situation where the supply of services is adequate but the services cannot be used by at least some members of the community.

In very general terms, I would posit that the kind of rural medical care problems found in the Great Plains, and further west, is a problem of availability. Conversely, the issue of accessibility is likely to be the predominant theme in the rural South. Rural communities in the Mid-West and Northeast likely suffer principally from accessibility problems, but I would judge their accessibility problems to be less serious than in the rural South.

Solutions to Accessibility Problems

From my experience, it is not possible to make any general statement about solving accessibility problems. The reason for this is that the specific barriers that lead to accessibility problems vary considerably from one rural community to another. This means each community must isolate the specific barrier(s) creating the problem and develop a plan of action to eliminate the barrier. Among the barriers frequently found in rural communities are the inability to pay for services, lack of transportation, inclement weather, language barriers, racial discrimination, and provider's office hours that do not mesh with the consumer's schedule.

Although it is not possible to make a general statement about solving the accessibility problem, I will make a general statement about the problem itself. It is my belief that the "market structure" for medical care in rural areas relative to urban areas creates significantly more accessibility problems for the rural resident. For example, many rural communities have but one or two doctors, and most have but one hospital. Other things equal, this monopoly position of rural providers will increase accessibility problems. For instance, if a rural community's only physician refuses to accept Medicaid (low-income) patients, they have no alternative source of care. In urban areas, these patients have a large number of alternative providers to whom they can turn. This increases significantly the probability that the urban resident will eventually receive needed care.

Solutions to Availability Problems

Communities that do not have enough services available have two basic choices: increase the supply of services available within their community or increase the ease by which their residents can secure services in neighboring communities. Frequently, the latter approach is not even considered, and in certain instances it represents a very viable alternative. Examples of this approach include the establishment of basic transportation services and improved emergency service transport in rural areas. For instance, helicopters have been used as a way of improving emergency service transport in some sparsely populationof the Great Plains and Far West.

The second basic approach for dealing with availability problems involves increasing the supply of services available within the community. In approaching the availability problem from this direction it is important not to become locked into what I call the "more of the same" syndrome. This syndrome refers to the tendency for some community groups to think only in terms of replicating or adding onto conventional delivery systems. By thinking in these terms, innovative alternative models of organizing services will likely be ignored. In some cases a different organizational model may actually preclude the need for additional medical resources. For example, research indicates that physician productivity is generally higher in group practice than in solo practice (5; 11; 22; 31). Hence, a community with three or four solo practitioners could likely increase its supply of services if its solo practitioners were to begin practicing in a group.

Other alternative models of delivering medical care in rural areas include primary health care centers, satellite clinics staffed by physician's assistants and nurse practitioners, and the use of mobile units and sophisticated telecommunication systems. Although a number of booklets and articles describe various models of delivering care in rural areas (4; 18; 23; 26; 32; 37-39), little research has been undertaken to evaluate the various models. An exception is the recent initiation of a fairly significant amount of evaluative research on primary health care centers. In addition, case studies of a particular model in a particular community have been undertaken, but only on a very random basis. Hence, I want to direct my final comments to the research community.

What is needed is a comprehensive and systematic research strategy that includes (1) the development of a typology of the various models of rural medical care delivery and (2) a critical evaluation or assessment of the models in each of several different types of rural communities. I see this kind of research leading to two important outcomes. The first outcome would be increased precision in identifying the most efficient way(s) of meeting medical care needs in each of the several different types of rural communities identified. The second outcome would be to use the research findings as a basis for identifying constraints which are beyond the control of individual rural communities. I believe that all too often these constraints prevent rural communities from implementing what is theoretically the best solution for their medical care problems. Let me give two examples.

Suppose there are several hundred rural communities who could have their medical care needs met most efficiently with a primary health care center staffed by two or three family physicians. Further suppose these communities can support financially such centers. However, if a national "shortage" of family physicians exists, at least some of these communities will not likely be able to implement the most efficient solution to their problem. The resource constraint in this case is not internal to the community, but is the external constraint of an inadequate supply of family physicians.

My second example stems from an excellent study of a satellite clinic staffed only by a physician's assistant in rural Oklahoma (20). The clinic was found to be medically feasible in that a reasonable number of patients were seen, patient acceptance was high, and the physician's assistant consulted and referred to the "home base" when appropriate. Although medically feasible, the clinic was economically infeasible. A major reason for lack of economic feasibility was because Medicare and Medicaid would not provide reimbursement unless a physician was present at the clinic. In this case, the external constraint was Medicare and Medicaid regulations.

Let me close by emphasizing that identifying these kinds of constraints is not enough. The responsible researchers must take one additional step. This step involves initiative in funneling the research findings into the policy-making arena. In the past, researchers have been woefully inadequate in this regard. Organizations such as the National Rural Center and Rural America are eager for research findings, and have the skills and contacts to translate academic research into appropriate public policy.

I realize the research strategy which I outline represents a major undertaking. However, if rural communities are to deal effectively with their medical care problems this kind of research and follow-up is essential. I shall leave you with that challenge.

Thank you.

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HEALTH SERVICES FOR RURAL AREAS

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Some fifty-six million people live in rural America. They reside in every part of the U.S. from the West and Intermountain region to the Northeast and the South. Between 1970-73 a significant reversal of the out-migration trend from rural areas occurred when the total growth rate of non-metropolitan areas (4.2%) exceeded the growth rate of metropolitan areas (2.9%).

Many people living in rural areas lack goods and services considered essential to quality living. A basic aspect for quality living is access to health care.

The two most basic health care problems of the rural areas are medical manpower and organization of services. The most acute needs are more primary care physicians and better organization of primary medical practice. Solving either of these would aid in accomplishing solution of the other. Adequate manpower enables the task of organization to go further than it otherwise could, and group organization of practice can make recruitment and retention of physician manpower easier to accomplish. Of the various methods considered for geographical redistribution of medical manpower to rural areas, the one that may hold the greatest promise is recruitment of physicians to organized groups.

Rural Health Situation

The "litany" of rural health and related problems goes something like this:

--Health manpower is deficient in relation to the population.

--Physicians are generally more elderly.

--Hospitals are more likely to be deficient.

--Public transportation is likely to be lacking.

--Communication service may be poor.

--Public and school health education programs are generally limited in scope and purpose.

--Rural areas are less apt to have comprehensive health planning agencies.

--Single practice rural physicians tend to experience long hours, lack of professional stimulation, and of continuing educational opportunities.

--Rural emergency medical services are generally very limited and, too often, not available.

The reasons for the rural health problems lie partially with the basic social and economic characteristics of rural areas:

--Rural people suffer from the "costs of space." They are relatively few and widely dispersed; therefore, more difficult and costly to serve.

--The rural tax base is low, both because the population is sparse and because of lower per capita income.

--Local rural government is fragmented into small and inefficient units, that are generally conservative and resistant to change.

--Rural people are less visible, less vocal, and less sophisticated than their urban counterparts in learning about or applying for assistance even though they are no less in need.

Health Services
Bond Bible

In 1969, the physician population ratio ranged from a low of 450 persons per physician in urban counties of 5,000,000 or more inhabitants to a high of 2,103 persons per physician in rural counties of less than 10,000 inhabitants. This is almost five times as many people per doctor in rural counties as in urban.

This does not mean that people in rural counties are without care, but it does have two important implications. First, rural people may have to travel longer distances to find medical care. Second, it may be difficult to get appointments with doctors because they already have more patients than they can handle. The shortage of physicians in rural areas is confined largely to specialists. General and family practitioners have been the main providers of medical care in rural areas, and the number of general practitioners in rural areas is actually somewhat higher per capita than in urban areas. However, there has been an overall decline in general and family practice caused by the increasing rate of medical technology and the consequent growth of specialties.

There should be better coordination among the operating programs of our general hospitals, which would help to avoid duplication in expensive facilities and services; but, more importantly, to gaps in other services. There is often poor medical care being rendered in the nursing homes and long-term care facilities in our country, and no real linkage between these units and general hospitals which could provide technical backup services and quality supervision for patients. Home health services are inadequately developed and inadequately linked with hospitals and with medical practitioners. There is, as yet, no effective overall linkage between general hospitals and community colleges and technical high schools in training of health personnel. There is a gap between our preventive medicine and curative medicine system, to the disadvantage of all our people.

The fact is that all of these problems are interrelated; and there is no single organization, agency, or governing instrument that has the capacity or the established leadership to solve them.

There is a desperate need for the various parts of the health establishment -- that is, the practicing professions, the university health centers and land-grant universities, the general hospitals and long-term care institutions, the public agencies, such as departments of health, mental health, and welfare, and a host of voluntary agencies -- to work together to solve these present problems.

Rural Health Care Systems

A rural health care system is a formal arrangement in which a variety of health care resources are linked together to provide for the delivery of the complete range of health services deemed appropriate for a designated geographic area or for a specified population.

Basic to the development of rural health systems is the initial planning by rural communities. It must be regional in scope, based on economic service areas. It must involve all segments of the community, provider and consumer alike, with support of planning agencies and government at the county, state, and federal levels. It must be elastic and tailored to the geography and the potential resources of the locality. Hopefully, the plans will always provide a "one door" service for all economic levels rather than serving the middle class or becoming an indigent clinic serving only the poor.

It is certain that many small communities that once had their "own" physician will never again have one. Clearly, for some rural areas, solutions completely different from the traditional "physician in residence" must be sought. In some such areas, emphasis may be needed on expanded transportation and communication capabilities, part-time use of physicians and allied health workers, improving biomonitoring technology, use of new physician support occupations, better understanding of individual health practices, and development of emergency care and self-help methods to ensure rural health coverage.

Regional Planning-An alternative, in some cases, may be area-wide cooperation. Thanks to modern transportation and communications services, physicians are not needed in every hamlet, village, or township. A number of communities within a trading or services area can plan together to develop health care systems on an area basis, to attract appropriate health manpower, and to provide home, clinic, and hospital care. Medical resources can be consolidated in much the same way that education services have been--if the "health services area" is carefully chosen. Some factors to consider are:

(1) Is there a sufficient population base at various age levels to warrant one or more physicians?

(2) Is the community capable of providing necessary financial resources to support personnel and facilities? (This would include eligibility for a variety of federal, state, and local funds, if the population base cannot support services on a fee-for-service basis.)

(3) Where do people travel for medical care at present?

(4) Are there readily accessible major health centers available in the larger community area?

The dimensions of a health service area within which residents can carry out integrated planning are likely to be already marked by trading or community patterns, drawn by residents as they drive to work, to shop, to school, and to recreational and cultural facilities.

Once such an area has been defined, regional planning can proceed to the questions of availability of transportation, adequate communications facilities, a thorough survey of present health status and needs, of available funding, and personnel resources. Several of the models that follow grew out of such study and illustrate the effectiveness of area-wide planning.

Transportation and Communications -- The finest health services in the world will do no good in a community unless residents have access to them, and to services and information beyond their area. Many rural areas are plagued by poor transportation which must be overcome not only for emergency cases but to bring the neediest patients -- who are least likely to drive or own cars--to treatment. Many communities organize volunteer emergency services, similar to the VFD, when clinics are established; in some minibuses link patients and services. Often, transportation to more distant medical centers is essential.

A growing use of telecommunications will shrink distances. They enable the health care team not only to extend its services but also to compensate for any numerical shortage in the team. They permit long distance transmission of findings and advice. Rural Health Associates of Maine, for example, uses closed-circuit television for instant consultation between its outlying facilities and the main one. X-rays of patients in the little town of Broken Bow, Nebraska, are transmitted by slow-scan television to the state university medical center in Omaha where they are interpreted. Good communication, such as two-way radio between hospital and ambulances, is indispensable to good emergency care in rural areas.

Community Organization for Rural Health Services

The quality of life in rural communities is frequently determined by the availability of health services. But in the provision of these services, many small towns have found that they must rely on their own resources. Large urban-based medical centers are not always equipped--either physically or by experience--to meet all the needs of a rural populace.

The experience of many small towns has demonstrated the effectiveness of Community Health Councils in custom-designed health care systems.

The Council can:

Analyze community health problems;

Establish local priority projects;

Facilitate communication among governmental, private, planning and program agencies;

Evaluate alternative solutions to critical health problems.

The Council can also act in a fund-raising or grant-seeking capacity and negotiate with neighboring areas having similar needs and problems.

To be effective, a health council must be able to utilize an existing organizational structure such as a health subcommittee of a regional planning body. But, eventually, the Council should be a self-standing body with consumer support. The fact is that health programs planned and operated without total community involvement are likely to be ineffective. Because the decision-making process of each community operates on a unique power structure, it simply is not possible to set concrete guidelines which apply to every town or every situation.

Mayor or schoolteacher, minister or farmer, physician or attorney-each can be the catalyst to start a Council in your community. Any service club, medical society, industrial group, or agricultural organization may take the formation of a health council as a project.

The composition of the group will probably change and expand as it begins its first task, which is to define the service area. It is important, however, to begin with a strong diverse leadership.

Through the U.S. Department of Agriculture's Extension Service and Rural Development Service and the U.S. Department of Health, Education, and Welfare, you can obtain information on existing federally funded health programs including: National Health Service Corps, Maternal and Child Health Services, Emergency Medical Services Systems Program, Farmers Home Administration, DHEW Medical Services Administration, Rural Health Initiative, and Health Underserved Rural Areas.

Determining the boundaries of the community health service area is your health council's first task. This may mean redefining "community," and perhaps further expanding the Council in the future. It's best if the "community" health service area closely parallels the retail economic trade area. This usually means at least two or more communities already linked by common business, social interests, and transportation systems. In sparsely populated rural sections, an entire county or several counties may be included in the service area. The U.S. Department of Agriculture's Extension Service can assist you with your demographic research.

The Council's second job (the first was to define the health service area) is to describe in detail the community's health deficiencies and propose solutions. Organizations which provide health services (e.g. health departments, medical, dental, and hospital associations, regional public Health Service offices) can assist the Council in developing a community health profile. Involving such groups helps not only to broaden the base of legitimate support for the Council, but enables it to identify a wide range of real rather than perceived health needs. Further assistance in surveying community health needs can be obtained by working with land-grant colleges, Cooperative Extension Service, and schools.

An example of a community health care services organization is the Southwest Minnesota Health Care Enterprises, (SMHCE), a non-profit, citizen controlled health system designed to serve 15,000 people in two counties. The towns of Lamberton and Jeffers are a part of this system, which explains why today there are two clinics in this area after so many doctorless years.

Six communities joined together to form the system and secured financial support from the Regional Medical Program (RMP). The Department of Family Practice and Community Health of the University of Minnesota Medical School did a survey of perceived wants and resources. A USDA official who was superintendent of the University of Minnesota's Southwest Experimental Station in the area, was a key leader in community organization.

On the basis of the findings and utilizing new concepts in group dynamics and medicine, a health care system was designed for SMHCE by the Medical School.

The system used new approaches to solve the problems of practicing medicine in a rural area. Among them were:

(1) Creation of an area-wide basis for a health system that would eventually serve a multi-community.

(2) Utilization of the county Extension Service to involve citizens.

(3) A financial commitment from the people in the six communities to fund the system until it could be self-supporting.

(4) Establishment of a long-range school and community health education program.

(5) Development of the ambulatory care concept that uses the hospitals and works closely with doctors already available in the larger region around the six communities.

(6) Putting administration of the system in the hands of the board of directors.

(7) Primarily this model indicates that health care is embodied in a system of which the physician is an integral part. More than a shortage of physicians, we have a shortage of systems.

Most symoblic of the success of the model is the fact that 11 area towns and 13 townships joined together in March, 1974, to form the Health Services Board of Southwest Minnesota, the first rural joint-powers agreement in the State.

Now that they have created a central group representing all the people of the area, they are able to work together even more effectively in planning a medical delivery system based on their needs as they see them. SMHCE is attracting a lot of attention because it is working. It works because the people care and have become involved.

One thing is clear from our past experiences in developing models for health care services. Behind all success is generally one man--usually a physician or a small group of men--a medical society or hospital board that have the creative intelligence, the vision to see what can be, and the strength to make it happen.

There has been increased recognition that solutions to rural health care delivery problems require an alliance of medical societies, schools and universities, farm groups, government agencies, and consumer groups. Emphasis is being given to the need for an area health service aproach with emphasis on group practice, health education, expanded use of allied health professionals, improved rural emergency medical services, and the need for relationships with medical schools, state and area Rural Development committees, health career councils, and other groups concerned with development of health care programs for the rural population.

This is as it should be. Just as a variety of approaches to increasing availability of care will be needed from one area to another, so success within a given planning area will require the involvement and support of a broad range of local groups and interests.

Some Positive Directions

Considerable study has been given to alternative methods for alleviating maldistribtuion of health manpower. Approaches currently under consideration or trail involve both attempts to relocate physicians and other health workers, and to develop alternative methods for ensuring availability of health services when needed. It must be recognized that acceptance of change in rural health care is a slow and gradual process. It is difficult for small rural communities to accept the fact that not every town can have a physician today. One resource available to help areas where health services are inadequate because of critical shortage of health personnel is the National Health Service Corps (NHSC). The program of the Corps is aimed at alleviating some selected and acute problems, and also for learning more about the use of NHSC type of programs as a strategy for addressing rural health manpower shortages.

The growth and development of family practice programs in medical schools is also noteworthy. Since 1969, eighty-one of the four-year medical schools have established such training programs. An outstanding feature in many of these programs is preceptorships or clerkships for family medicine in a community setting. In addition, approved family practice residency programs have reached 260, and the number of residency positions is approaching 4,000.

A relatively new health manpower program directed in a large measure to rural health care is the area health education center. The key word in the area health education centers system is linkage. The center is a system or an arrangement rather than a place; a system that links health services organizations and educational institutions in a way that serves the student, the practitioners, and the community.

The increased utilization of physician's assistants and nurse practitioners to extend the services of physicians can expand health care services to more rural people in the Midwest. As of March, 1975, 38 states had enacted legislation establishing some type of regulatory mechanism for PA's. There are two distinct statutory forms to grant legislative sanction to physician's assistants. The delegatory statute adopted by 18 states simply spells out in the state medical practice act the physician's recognized right to delegate tasks to a trained assistant. The regulatory statute enacted in 18 states authorizes a specific organizational entity, usually the state board of medical examiners, to establish rules and regulations. The AMA recommends that such mechanisms be enacted in the states.

The MEDEX approach to the training and deployment of physician extenders has been quite successful in rural areas. In a recent survey of 277 MEDEX graduates and 297 trainees, it was found that practically all of the graduates and trainees are employed in full-time practice and are working with fee-for-service family physicians in the rural areas of the U.S. This suggest that the strategy used to place MEDEX practitioners in communities requiring additional health services has been successful.

In a recent issue of JAMA (10-20-75, pp. 303-304), the Jamestown (New York) Medical Clinic System was discussed. This interesting abstract preceded the paper:

> "Comprehensive health care can be provided in rural and poor areas despite a decreasing number of physicians in those areas. A single physician increased his productivity by 300% to 400% by combining already available resources: Specially trained and supervised nurse practititoners, problem-oriented charting, and multiphasic screening."
>
> "With emphasis on the nurse practitioner as the main 'person of contact' for the patient, the physician is able to shift from 50% to 75% of his usual tasks to these specially trained personnel."

There are a number of opportunities available which, if utilized and expanded, can have an impact on the health manpower problem in rural areas. They inclued:

(1) the growth and development of family practice programs in medical schools.

(2) the recruitment of medical students, who due to their background and motivation, are more likely to select rural locales for their practice.

(3) planned exposure of medical students to rural practice and life style during their medical school education.

(4) direct medical school involvement with local communities in helping to deliver health services as a part of their medical education program.

(5) the AMA Physicians' Placement Service as well as the state medical society placement service provide a mechanism to bring physicians and communities together.

(6) the National Health Service Corps which helps to provide health personnel to areas of critical need.

(7) the training and utilization of allied health personnel to extend the services of the physician--nurse practitioners and physicians's assistants.

(8) publications on community organization and direction in recruitment are available from AMA, HEW, and state universities.

(9) the development of continuing medical education programs which are available and accessible to rural physicians.

Another problem of special concern is the tendency for each rural town or community to want their own independent health care system. There is a need for multiple communities in a logical service area to plan together to develop health care systems. Such systems set up on an area basis will attract appropriate health manpower working in a group to provide home, clinic, and hospital care. The elements of a health care system can be grouped under the headings of personnel, services, community organization, and funding. Opportunities available in this area include:

(1) the development of a number of models for health care delivery affords an opportunity for rural community leaders to study plans and adopt plans suitable for their needs.

(2) the growth of group practice arrangements is one potential means of attracting physicians to rural communities.

(3) a number of rural health bills introduced into Congress aim to support the development of rural health care models. They all would call for the creation of an Office of Rural Health within HEW. One of those was developed by the AMA.

(4) the USDA Rural Development program is another resource to help rural areas in planning for health services.

(5) there needs to be effective relationships established between hospital medical staffs and hospital governing boards in the rural hospital.

(6) the Emergency Medical Services Systems Act Amendments of 1976 provides grants for operating an emergency medical service system, and planning for the system. This is an important resource for rural areas since 20% of the funding is designated for the rural sector.

Let us remember that there are ways to close the gaps by providing health services for rural people.

(1) There is need to place continued and increased emphasis on family practice programs in medical schools.

(2) The development of quality family practice residency programs must have much greater state and federal support.

(3) Support and assistance should be given to programs that would increase the number of medical school graduates who have a rural background.

(4) Establishment of group practice is one potential means of attracting physicians to rural communities. Availability of a suitable group practice opportunity is not only important in attracting a physician, but it is apparently important in retaining him.

(5) Resources must be sought to develop and implement comprehensive continuing medical education programs for rural physicians.

(6) Physician recruitment in rural America could be aided by a central clearing house. Conceptually, this could involve obtaining profiles for selected interns, residents, and other physicians desiring to select a new practice site, while at the same time obtaining profiles for recruiting regions. Physicians and regions could then be matched based on certain areas of common values.

Utilization of Resources

The principal resource of any area is its people, and the ultimate goal of any program is to raise the level of human well-being. Remedial health services are indispensable to the pursuit of that goal. But in the long run, self-maintenance of health and prevention of disease are at least as necessary.

Careful longitudinal studies are beginning to corroborate the records of insurance companies, the observation of practicing health professionals, and plain commonsense as to the positive relationship between good health habits, better health, and longer life. For example, Dr. Lester Breslow, Dean of the School of Public Health, UCLA, and colleagues conducted studies of 7,000 adults over 5½ years. The results showed that seven simple health habits--three meals a day at regular intervals, eating breakfast, moderate exercise, 7-8 hours of sleep each night, moderate weight, no smoking, and no alcohol or only in moderation--were associated with longer life.

Specifically, a 45 year old man who practices 0-3 of these habits can expect to live to about 67. A man with 6-7 of these habits can expect to live to 78, a difference of 11 years. The study also reported that the physical health of those following all seven good habits was consistently about the same as those 30 years younger who followed few or none of these practices.

It appears that two generalizations with respect to the effectiveness of current health education and behavior change programs are justified. First, proponents can point to a number of carefully documented success stories that can be interpreted as having reasonably wide application to similar programs. These involve primarily individuals who already have some strong motivation, patients with a chronic illness or disability, those facing an acute crisis such as surgery or childbirth, or employees whose livlihood may depend on overcoming alcoholism or some other job-threatening condition. Secondly, if individual behavior change programs are to be generally effective, they must be accompanied by firm professional guidance and by national policies and mass communication programs designed to reinforce, rather than undermine, the message of health education.

Finally, all of us must recognize that "health does not exist in a vacuum." Health is but one aspect of the "quality of life" which includes all the socio-economic, ecological, and educational factors which make for a satisfactory living situation. To improve rural health, we must also address the totality of deficiencies in rural living today.

GOVERNMENT FINANCING OF RURAL HEALTH CARE

By:
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In the twelve months ending June 1975, spending for health care in the United States totaled $118.5 billion, or approximately $470 per capita. This represents a tenfold increase since 1950 when expenditures totaled $12 billion. The $14.5 billion increase in spending from 1974 to 1975 easily exceeded the total 1950 spending.

What are the sources of funds for these expenditures? Direct private payments total approximately one third of health care expenditures (Table 1). Twenty-seven percent of health expenditures are funded from private insurance benefits. The remaining 40 percent is said to come from Federal (28 percent) and State and local (12 percent) governments.

Table 1
Per capita expenditures for personal health care

Sources of funds			Percent increase 1965-1975
Direct Payments	$89.37	$155.10	73.5%
Private Insurance Benefits	42.10	126.21	199.8
Federal	14.44	131.92	813.6
State and Local	20.94	56.99	177.2

Source: U.S. Department of Health, Education, and Welfare, Social Security Administration.

A closer look at these sources of funds is necessary to understand their impact and equity. Although recent statistics are not available, some indication of how out-of-pocket health care expenses affect the average family are available from 1970 data. Table 2 clearly shows that higher income individuals spend more on health care; however, health care expenditures represent a greater percentage of income to low income individuals.

Table 2
Out of pocket expenses as percentage of family income: 1970

Family income	Out of pocket expenses as percentage of family income	Average amount spent
Under $2,000	14.5%	---
2,000 - 3,499	9.3	256.00
3,500 - 4,999	7.7	327.00
5,000 - 7,499	6.1	381.00
7,500 - 9,999		402.00
10,000 - 14,999		475.00
15,000 and over		---

Source: Ronald Anderson, et.al. Expenditure for Personal Health Services: National Trends and Vacations 1957-1970,)October 1973), Table 5.

Our concern today, however, is more with government financing of health care expenditures. During fiscal 1975, cash government expenditures for health care totaled $49.9 billion. Add to this $8.0 billion in federal tax preferences and we find government support for health expenditures equal to nearly $58 billion.

Clearly the government's role in health care is significant. It is important to develop an understanding of the economic justifications for government involvement in financing health care. Then we will consider whether the funding is equally available to all individuals.

Government Financing of Rural Health Care
William Fox

There are two economic justifications for government involvement in providing adequate health care. First, significant externalities exist in the provision of medical services. Externalities exist whenever the benefits of a good or service accrue to individuals other than the direct recipient. One externality is that a health population is more productive. A productive rural America benefits both urban and rural areas by providing more goods and services for everyone to consume and by lessening the incentive for the rural poor to migrate to urban areas. Externalities also exist because the best way for me to avoid getting a communicable disease is to insure that my neighbor does not get the disease. I derive benefits, therefore, from my neighbors' health care. A final externality emanates from the community leadership and development which often accompany the location of health care professionals.

Government financing is essential to insure the proper provision of goods where externalities exist. The appropriate level of government to finance the services would be one large enough to incorporate all of the externalities. The federal government's role in rural health care can be strongly supported by the potential for greater rural development and the problem of preventing the spread of communicable diseases. Local government also has a role in financing health care because of the community development and leadership potential available to the local community from the presence of health care professionals. Also, the risk of getting a communicable disease is greatest at the local level.

The second justification for government involvement in health care financing is to distribute income more equitably. Provision of adequate health care can be an effective way to achieve a more equitable distribution of income because once started, the increased productivity of the people will help sustain the equity. Income distribution is best accomplished at the federal level so a further federal role in financing health care services is encouraged.

Has government financing of health care been equal across rural and urban areas? Medicare and Medicaid are currently biased against the rural poor. In 1969, Medicare monthly reimbursement per person enrolled was nearly 40 percent higher in metropolitan areas than in non-metropolitan areas (see Table 3). Monthly reimbursement for physicians' services was nearly 50 percent higher in urban areas.

Table 3
Medicare average monthly reimbursement per person enrolled in metropolitan and non-metropolitan counties, by region, January-December 1969

	Metropolitan counties			
	with central city	without central city	Nonmetropolitan counties	Ratio, central city counties to nonmetropolitan counties
Medicare monthly reimbursement per person enrolled				
United States	$29.85	$27.12	$21.16	1.41
Northeast	31.52	28.73	23.14	1.36
North Central	28.65	25.52	21.61	1.33
South	25.60	23.33	19.44	1.32
West	33.82	31.59	23.91	1.41
Medicare monthly reimbursement for physician services per person enrolled				
United States	$8.53	7.40	5.48	1.56
Northeast	8.70	8.04	5.93	1.47
North Central	6.80	6.07	4.98	1.37
South	8.23	6.56	5.33	1.54
West	10.79	9.79	7.08	1.52

Source: Eugene C. Carter, "Health insurance for the aged: amounts reimbursed by state," U.S. Department of Health, Education, and Welfare, Social Security Administration, Office of Research and Statistics, H1-32, October 19, 1971.

Medicare payments have not been effective in reaching the rural poor partly because reimbursement to clinics can only occur when a physician is in direct control of the clinic. Medically underserved areas are concentrated in rural areas as evidenced by the fact that approximately 430 rural counties do not even have a physician. In many cases, therefore, Medicare payments cannot be made in rural areas.

Availability of Medicaid reimbursement is linked to eligibility for AFDC and other welfare programs. Seventy percent of the rural poor can be classified as two parent, working poor who are generally not qualified to receive welfare. Therefore, the rural poor often does not qualify for Medicaid.

State and local government spending also suffers from certain limitations. Six billion dollars of state spending for health goes for Medicaid, and so is also biased against the rural poor. An examination of the sources of funds for local health care spending in the south reveals that the bulk comes from current charges. Local governments in the south which represent 50,000 or fewer population, spend an average of less than three dollars of local taxes on health care. Counties with more than 100,000 population on the other hand spend an average approximately $12 per capita of local taxes on health care.

Table 4
Sources of funds for health and hospitals expenditures by local governments in 11 selected southern states

		County Population Groups					
Source	Total	250,000 or more	100,000 to 249,999	50,000 to 99,999	25,000 to 49,999	10,000 to 24,999	less than 10,000
Current charges	24.49	16.37	32.44	30.10	27.59	24.65	20.95
	(71.4)	(49.0)	(73.8)	(82.7)	(87.2)	(85.3)	(79.4)
Intergovernmental aid	1.94	2.44	1.53	2.21	1.36	1.61	1.62
	(5.7)	(7.3)	(3.5)	(6.1)	(4.3)	(5.6)	(6.1)
Taxes and other	7.86	14.60	9.97	4.08	2.70	2.63	3.82
	(22.9)	(43.7)	(22.7)	(11.2)	(8.5)	(9.1)	(14.5)
	34.29	33.41	43.94	36.39	31.65	28.89	26.39
	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)	(100.0)

Percentages in parenthesis
Source: U.S. Census of Governments

What are some funding alternatives to improve the problems of health care in rural areas? Several important changes seem appropriate. First, physician reimbursement under Medicare Part B should be extended to reimburse clinics in rural areas without a physician present.[1] This idea, presently before congress as S.708 and H.R. 2504, would have the effect of helping the HURA clinics to remain financially solvent. Also, by limiting the reimbursement to clinics in medically underserved areas the location of medical facilities in rural counties is encouraged.

A second suggestion would be to eliminate the link between Medicaid and welfare programs.[2] This would make Medicaid reimbursements more available to the working poor which are dominant among low income groups in rural areas.

Reimbursement for Medicare is limited to the 75th percentile of charges currently made within the reasonable charge locality. Each state is broken into a number of reasonable charge localities resulting in reimbursement in rural areas that is often much less for the same service than in an urban area. Another suggestion would be to establish each state as a reasonable charge area.[3] Therefore, reimbursement limitations for each service would be identical throughout the state. This technique for physician reimbursement would reduce the opportunity cost to physicians of locating in rural areas, thus encouraging the location of physicians in underserved medical areas.

A final suggestion would be to consider increasing local tax financing of health care in order to account for externalities. Current levels of local spending often appear too small to encourage community development. Yet, the local government has a vital stake in insuring adequate health care for its residents and may find the benefits of additonal local spending far exceed the costs.

References

[1] See Irma T. Elo, "Regional and Residence Variations in Medicare and Medicaid Reimbursements," Economic Development Division, USDA.

[2] Ibid p. 16.

[3] A further discussion of this idea is available in James R. Cantwell, "Physician Fee Variation and Reimbursement in California and Georgia," presented at the Western Economics Association Meetings, June 1977.

"I'LL TELL YOU WHO I AM"
A Rural Perspective
on
Social Welfare Consumers, Policymakers, & Providers

By:
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This paper, originally prepared for an oral presentation on dilemmas experienced in delivering social welfare services in rural areas, gave me the occasion to somewhat systematically question rural practitioners in my neck of the woods regarding their perceptions of problems experienced in rural practice. Eventually, one of them confirmed my own experience and suspicion: people, themselves--those who experience human needs, those who write policy and design social welfare programs to respond to human needs and those unfortunate souls in the middle, the human service providers--all of them, plus other configurations of people involved and attached, create the major dilemmas in delivering social welfare services in rural areas. Woe is us, for our strength is our weakness! Or if you prefer Pogo, "I have seen the enemy, and he is us."

Let's look briefly at each of these "people" from a rural perspective.

Social Welfare Consumers in Rural Areas

I am aware that there are as many "kinds" of rural folks as there are urban folks. We are definitely not homogeneous. Some rural areas have become over-populated to the point of economic depression as family farms are divided and grow ever smaller. Other rural areas, particularly in the western United States, are populated with vast ranches which create enormous incomes for their owners, if for no one else! Rural folks may be similar only in that we are increasingly a minority group in the United States.

My observations grow out of my past and present in Southern, non-coal Appalachia. To the extent that they may relate to your situation, I hope you will find them useful.

We Southern Appalachians are, first and foremost, bound to the land. If we do not currently live on a farm, we are likely only a generation removed. The land for us has always been our independence and source of identity. Furthermore, the rugged, mountainous terrain has mandated that we be fiercely independent.

In years past the land gave us what we needed. It produced our food, our clothes, our shelter, our water, our heat in winter and shade in summer. We are proud of our history of maintaining life-sustaining necessities, and with it, independence.

Our independence has been threatened on every side. We have been exploited. Waves of people have systematically ripped off our coal for northern industries, our timber for fine furniture and homes, our water for hydro-electricity (now they want it for drinking) and our people for cheap labor. Our land has been consumed by national forests, tourists, and summer homes. But most of us still have a little piece of land, and we are proud of what we've got.

Television, in the form of "Hee Haw" "The Beverly Hillbillies," may have been, in the final analysis, the biggest rip-off of all. Economic exploitation is one thing; psychological exploitation is another. Our pride has been seriously challenged by bombardment with the consumer-oriented, dominant culture. That world on the TV screen is not our world and we know it. And because it's there and we're here, it's elevated and we're not, our pride has suffered. Those of us who could "pass" in the dominant culture call it a question of values, but those of us who can't "pass" or don't believe we can "pass," experience it as demigration. The dominant culture not only exploits our economic resources but our hearts. "They" make fun of us. We know it, and it hurts.

We struggle. We struggle between oldsters and youngsters, between staying and leaving, between lining our pockets and filling our hearts. We struggle over definitions of life-quality and who makes the definition. All of us know that contrasted with the urban affluence on the TV screen, none of us--not even our "professionals," our "politicians," our few "big farmers" have thickly lined pockets. Some of us have lost the struggle and introjected this dominant cultural image of who we are; others of us, by roots and grace, are shaking our fists and shouting, "I'll tell you who I am." Intrapsychiacally, our struggle is akin to that of all minority groups.

We rural Appalachians are still proud. Our greatest pride is our families. We have big, extended families and because they are present and important for us, we feel sadness and suspicion for people who aren't attached to a large family. When we need help, we turn to our family members. Their response, while it may not be exactly what we want or even can use, is immediate and genuine. We have very limited awareness and practically no experience of getting help from someone outside our kinship/friendship network.

Because we inherit land from our families and because of our particular mountainous terrain, our families are bound together in communities bordered by ridges, creeks or other natural barriers. Since transportation in the mountains is slow year-round and sometimes impossible in bad weather, our reliance on our family and community is reinforced. It is not unusual for someone to move less than fifteen miles distant, and still long to return "home."

Urban outsiders tend to think our communities are unorganized or, at best, disorganized. Nothing could be farther from the truth. The speed with which we can communicate an event of signifinance is exceptional compared with anywhere in the United States. In the same sense, outsiders tend to overlook our unique forms of volunteerism. Few rural persons who have ever experienced a crisis, such as being burned out of their home, live to report a lack of caring and responses on the part of their community. Our communities are organized familially and informally rather than associationally. Our social institutions, particularly the church, the school and political organizations are extensions of our kinship and friendship systems. All institutions are component parts of our familial system and is a real sense to contact a component part is to contact the entire system.

As a component part of the larger family system, the political system's primary function is to act as an informal welfare institution. Due to scarcity of jobs, most jobs are "political" and go to persons grafted into the extended kinship/friendship group in political power at any given time. Since rural political systems are smaller than urban ones, they are more transparent. Rural politicians are not adept at the fine art of sophistication and therefore do not hide political pressure as deftly as urban politicians do. The smallness of the political order means political pressures and realities are felt throughout the system rather than purely by the top men who gather in smoke-filled lounges over a drink and veil their politics under social sophistication.

Values grow out of experience and it is not surprising that rural people value and prize highly familial association. It is the family that defines the individual; the family tells me who I am. If my family prizes church involvement, I do; if my family prizes upward mobility, I do; if my family prizes hard work, I work hard; if my family prizes education and tells me that's how to "be somebody," I will seek an education.

The family defines and reinforces acceptable behavior. Unacceptable behavior is curbed by rumor and if that doesn't work, violence may be invoked. How the individual behaves is a reflection on the family, and the family reputation is to be protected at all costs. Since an individual is unlikely to take any action which violates his/her values, all of us must know what values we and others hold, how they are transmitted and upheld, and how expensive will be the consequences of actions that go against existing values. Examples of actions that may likely violate existing values in rural areas include abortion, divorce, and political action that is not perceived to bein the interest of the extended family.

Finally, the world of many rural folks is a concrete world. We are not given to analysis, abstractions and/or generalizations of thoughts or feelings. We tend to see specific cause and effect associations. Our lack of experience with generalizations makes it difficult for us to grasp the "larger" issues and systems that may oppress us. Our allegiance to our families keeps us uncritical of how we get scripted for specific roles and held to them (even when they break our spirit), of how family reliance may rob us of full adult independence, of how we fight tooth and nail sometimes within the family but close ranks very quickly when an outsider makes a challenge.

Our lives are characterized by "givens." We are born to families that may or may not have political power. If we are "out" it rarely occurs to us that it could be any other way. We accept the seasons of our lives very much as we do the seasons of the year--if you don't like winter you can't change it, just wait until spring. We are deeply spiritual (sometimes religious) people. The same Power which causes sun and rain to nurture our crops or destroy them is the Power of wealth and leanness in our lives. We accept a human tragedy very much as we accept a hailstorm before harvest and we are much more likely to respond to a crisis than to plan how to avoid one. Some people call us fatalists; others say we may have a fairly realistic sense of just how much is within our control and how much is beyond our control. Above all, we are human--full of human potential and acquainted with human weakness.

Social Welfare Policymakers from a Rural Perspective

It will become quickly obvious that I know a lot more about rural social welfare consumers than I do about social welfare policymakers. I know something about how the policy gets made and how it affects rural areas. And while I would like nothing better than to label the policy-makers a "they," I believe "they" must become a "we" if we ever expect to get adequate social welfare services to rural Americans.

Social welfare as an institution in the United States grew up in urban centers. Long before rural folks got our pride challenged by the media, out-migrants and immigrants who become urban dwellers knew both economic and psychological deprivation. Robbed of familial resources, they had no choice but to turn elsewhere. The private sector, most notably in settlement houses, sprang up to respond to human conditions in urban areas. Associations were formed to take care of their constituent member. As ethnic associations rested political power in urban centers, the political system began to function informally as a welfare institution. Eventually, as demand increased and informal supply diminished, the welfare system became an institutional resource system. As it became institutionalized it became centralized and bureaucratized, less intimate but highly efficient and effective (or so we are told). It also became quite costly.

I believe most of you would agree that we have arrived in the United States today at a place where human dignity and life quality, articles of our country's founding papers, are diminished hourly by an economic system imbued with Social Darwinism. Too large a portion of the population is more concerned with individual achievement, success and profit than collective well being. And a "welfare system for the rich" increases their advantage.

"I'll Tell You Who I Am"
Fay Walker

The political arena is the battleground where people challenge the economic interest of the few, and rural Americans--both by our own unawareness and timidity and outright intimidation from others--have not been adequate for the political battle. Systematically, rural Americans get a disproportionately small piece of the resource pie, and it's not only the size of the piece but the way it's served that hurts rural folks.

The demands of urban dwellers, their numbers, their vociferousness and their history of cashing in on threats to do something if their needs aren't met, make them a potent lobby when the human resources pie is out. Furthermore, it is possible to respond to human needs in urban centers through a centralized, bureaucratized societal structure. This may well be the most effective and efficient way to serve the pie even though human dignity is reduced when the server spills the crumbs.

Rural folks don't understand impersonal, centralized and bureaucratized societal structures. Our families and friends help us and when they can't or won't, we simply don't know what to do. We don't know how to apply for help; help is not something we receive; it's something we exchange. It humiliates us to ask for help when there's no response we can make later in return. So we keep exchanging help and holding on to our dignity. The statistics that demonstrate that best come from those rural counties, like my own, where the proportion of the population below the poverty line far exceeds the proportion of the population on public assistance. Sure, rural people have needs that we nor our families can meet. Sure, we need health and welfare services. But what's out there (if we know about it) and what we have to go through to get it (if we know we can) is too expensive to our dignity and we'd rather do without than suffer the humiliation.

I believe this is the dominant attitude toward all social welfar programs in the rural areas I know best and it will likely continue until all the people involved--consumers, policymakers and service deliverers --start speaking loudly, listening carefully, and creating humane structures and strategies that allow people to exchange resources without loss of human dignity.

Human Service Providers in Rural Areas

Human service providers in rural Appalachia fall largely into two groups: indigenous people usually employed through the political system doing a hard job the best they can, and outsiders from other rural areas or urban areas frequently imported because the bureaucracy for which they work requires an educational level that few local people have attained.

Whether "insider" or "outsider" rural human service workers have several things in common. First, they struggle daily with the disparity between the magnitude of human need and the scarcity of available resources. They work for small, understaffed, under-financed agencies. Public programs underestimate the cost of getting social welfare services to rural people. Transportation is almost always the priority problem of a rural practitioner. Local governments, operating off a small tax base, cannot compensate for programs that overlook rural transportation realities. Our rural agencies have very few mid-management positions. Consequently, a line worker may feel very little support within the agency structure in terms of supervision, consultation, staff development experiences, etc. Agency leadership is frequently not prepared for administrative, planning, and management functions and gets little support from the larger, parent institution to develop these skills. Finally, all human service workers in rural areas experience from time to time the burdens of identification with the involved profession of social work-- we wonder if we ever please any of the people any of the time.

The indigenous worker frequently has the advantage over the trained imported worker because of his/her experiential knowledge. The indigenous worker knows the community, its people, their values, and their social and political precesses. This knowledge may, however, be very expensive. It is difficult to see the larger picture, particularly the interplay of policy, politics, and economics if one's experience keeps one nearsighted. Alignment with the kin and friendship system currently in political power may limit a worker's effectiveness in working with families not currently "in." The indigenous worker's value orientation coupled with awareness of clients' personal and familial histories may lead one to operate on assumptions about a given client that diminish a worker's interest or capacity to facilitate client self-determination. And finally, confidentiality is always an issue. The smallness of our system means we all know one another. Many of us are related and "secrets" are hard to conceal.

For the social services worker imported from outside the rural area, the barriers to effective practice are many. First, is the limited (and often negative) experience rural people have had with previous "outsiders." Nothing in our experience leads us to trust the oursider until the outsider proves, sometimes repeatedly, to be trustworthy. If the outsider is not at home with rural ways, he/she may have particular difficulties. Refusal to accept rural folks as we are, eagerness to define others rather that willingness to be defined by them, limited understanding of familial and community dynamics, misunderstanding of political processes and systemic association, and compulsiveness to change the rural scene to fit graduate school models may lead to the demise of an otherwise well-intentioned social worker. The demands of rural practice far exceed, in my judgement, the demands of urban-based practice. For the graduate school professionally trained social worker, a primary task may be learning or re-learning how to carry on what one such practitioner called a "rural dialogue." The educational process, with its emphasis on analysis, abstractions and generalizations teaches us to live in a conceptual world--a world far removed from the concreteness of rural people. Graduate schools teach us to diagnose, to fit people into our treatment modalities. Effective rural practice requires that we fit response to expressed need. Equally significant, a graduate school model of a clean, pure, democratic process is no more at home in a rural area than it is in an urban area. Images of political purity exist only in the ivory towers of academic models.

Social service educational progrme at both the undergraduate and graduate level have an urban bias as does the social welfare institution they prepare people to staff. If educational institutions are not willing to forego this bias, it will be left to the individual professional to bridge the gap. The overwhelming demand in rural areas is for social work generalists, not specialists.

The rural human services worker, whether indigenous or imported, is in my judgement a critical link to improving the quality and quanity of social welfare services available to rural people. I accept as a basic tenant of social work practice that it is how help is offered that allows people to receive and utilize help without compromising their dignity. If that is true, the dignity and potential of rural practitioners must be tapped and developed if they are to build a sense of self-worth in those whom they serve.

Implications and Alternative Directions

Even though I grew up rural and have once again taken root in a rural area, the years I spent bettering myself in higher education shaped my critical and analytical skills. They did not give me answers to complex problems! In summary, I can only point toward some directions. I believe they are worth your consideration.

Underlying my suggestions are two assumptions: First, we must develop an ever-increasing regard for one another. Whether we are consumers, policymakers, or service providers we must act, if from no other basis of respect, from the awareness of our common destiny. We must initiate dialogue whenever possible to increase human understanding and build up human community. We must attack the forces that dehumanize ourselves and others in whatever forum we have, whatever structure we relate to, with whatever skills and ability we can master. Intervention at all levels is necessary and we simply must not lose the struggle for human dignity in endless skirmishes over whose way is the right way or the misassumption that there is only one right way or the arrogance that we can do it alone.

Secondly, we must learn to trust one another and to behave in ways that foster trust. Rather that "we" vs. "them","insider" vs. "outsider" we must develop human community where difference is respected, commonality is celebrated and everyone who would build up community is allowed and encouraged to participate.

I do not make these statements as platitudes. Rural folks know as well as anyone how easily we are divided and win the battle but lose the war -- sometimes because we didn't even know it was raging.

The war I see raging now is one to hold onto our dignity while we still have some left. How can social welfare services in rural areas speak to that issue and help in the struggle?

1. The welfare institution can stop being one of the instruments that rob rural people of dignity and, if the institution can't do it, then the humans that staff it can attempt to by the manner in which they link people in need to available resources.

   Educational institutions, particularly those located in rural areas, can assist by reversing the urban bias in social work education and by making possible degree-oriented education, in-servicetraining, and continuing education opportunities to people presently employed in rural social welfare agencies. Such a commitment calls for the training, re-training and continuing training of indigenous persons rather than the displacement of indigenous people in favor of an imported worker educated outside the rural area. (For a model of such a program, read the article, "Educators and Practitioners Work Together For Professional Development of Rural Social Workers" to be published in a Reader from the 2nd National Conference on Social Work in Rural Areas.)

2. Rural social service practitioners themselves must become innovative in new models of service delivery. Repeatedly rural practitioners lament the lace of coordination and integration of social services in the rural area. We know first hand the fragmentation and lack of availability of services that results as a highly structured, centeralized and bureaucratized welfare institution is imposed on rural culture. We know that current program policies and structures mitigate against decentralization of services. On the other hand, we know that the more decentralized the services, the more informal and natural the setting, the more personable the worker, the more human resources are sought and used in rural areas.

We cannot wait for the planners to plan for us and we dare not wait for policy to undergo surgery. We must initiate cooperation and decentralization locally - line staff in local human service agencies being the leaders in this activity. Wherever we can work in terms, however we can facilitate referrals, however we can make the social welfare institution, foreigner that it is, wear the informal personable, interlocking posture of an extended family system, we must. We've got to stop protecting agency "turf" and image; stop identifying ourselves as self-support agencies over against those who give government handouts; stop playing one-up/one-down based on the educational level of employees; and, if it keeps us from cooperation in getting the best services to the most people, stop playing consumer control over against politically appointed boards. Agencies and institutions can't do that, but people in them can and as they do, agencies are renewed. That's the kind of change that can't be legislated from top down, but grows from the bottom up as line staffers use themselves as resources for decentralization and coordination of services.

3. There are clearly many things the front line social worker cannot do. Historically, agency status in rural areas has been gained vertically, not collaboratively. Is this kind of status functional given the goals and objectives of human service agencies in rural areas? I suspect not! Rural human service agency directors need to start talking about finding decentralized spaces - multi-purpose physical structures that house day care, health clinics, and on rotations workers from DSS, mental health, employment security, vocational rehabilitation, etc. And we don't have to wait until funds are appropriated to build such facilities. Existing community buildings, especially churches,

community centers and schools, stand underutilized. The local school (if consolidation hasn't closed it) is an institution all rural folks identify with. Why can't the "community school " concept be utilized in more rural areas? If help is something rural people exchange, why cna't community involvement be exchanged for personal services?

4. Our task might be easier if we had more resources-- private and volunteer agencies -- as well as more realistically financed public agencies capable of delivering services to rural residents. Many rural areas have no local United Way and therefore do not have, in the private sector, the funds capable of multiplying dollars through matching grants. In some locations, creation of such a resource makes sense, particularly if there is enough local industry, a pool of ready responders, to support it. In other rural locations, rural people are systematically tapped as United Fund contributors in not-so-distant urban centers where they work. These monies rarely get back to the communities in which the workers live and raise their families. Instead, they benefit exclusively the city or county in which they are collected.

I believe there is an issue of legitimacy here that rural folks have overlooked. Either we must encourage rural people working and contributing in urban centers to designate their contributions be returned to their home county and/or to put leverage on fund gatherers to serve outlying rural areas, or to refuse to contribute at work and start a similar program in the locale where their children and neighbors will benefit.

This situation is not only true of the United Fund but of numerous speciality services, many publicly financed, that are located in urban centers, mandated to serve a larger catchment area, but in reality serving only urban dwellers. I personally feel this is a violation of public trust and professional ethics and I support using whatever leverage is necessary to get for rural people the services we have a right to. Again intervention at a number of levels is called for.

So far, most of the directions I've pointed toward are actions that could be taken on the local, county level and are consistent with rural realities and processes as I perceive and understand them. It is obvious that I have not talked much about planners, model-builders, councils of government, regional commissions, state or federal policy makers of implementors. I've avoided that for reasons I would like to make specific.

Rural people have no history that confirms "bigger is better." Quite the contrary, "bigger" has more often meant a smaller slice of the pie for rural people. And as that's happened, we've become more easily intimidated by the "hand that's supposed to feed us." Quite frankly, the size and formality of that level of bureaucracy scares me. Some of us still harbor some hope that the council of government or the regional commission is going to help. Others of us are tired of being studied, told what we know we don't have, merged into larger systems that may be more efficient at planning but are marginal in delivering.

Our waiting has been costly -- among other things, it's cost us initiative, a human commodity once strong among rural people. My purpose here is not to discount any positive work done at the COG or regional level, but more to suggest we best not rely on that level to inform either the quantity or quality of social welfare services in the rural area.

Rather, I think we could best enlist them as allies in our struggle with the still larger system that they are designed to interface. Perhaps COG's and regional commissions --no, a few individuals within them-- might hear, if we spoke loudly, specifically and concretely, the state of human welfare in rural communities. Perhaps some few of them might be inclined to lead us on a tour through the bureaucratic maze. If so, I hope our van will be full.

I hope we'll all go -- consumers, providers, politicians, supporters -- I hope we'll go to Raleigh, to Washington, to wherever. I hope we'll take our courage and our wisdom along with our scares and scars. I hope "they" won't look like they do on TV. I hope they'll agree with me that everyone's dignity is at stake. Somebody will prophsey "what does it profit a man if he gains the whole world and loses his soul." Someone with different gifts will present a few facts and figures. Someone will judge "it's not right the way it is." And maybe someone will remind "them" of violence in rural areas and how people everywhere explode if they're denigrated long enough. And we just might clog in front of the White House -- people have danced there before and gotten noticed.

The warmth of social change is brewing. People in rural Southern Appalachia are shaking our fists and saying, "I'll tell you who I am." Human service consumers and providers are compelled to join the struggle for human dignity. Our very survival, as we have known it in the past, is at stake.

A paper contributed to and nurtured by human service providers in Madison and Yancey Counties and faculty at Mars Hill College, Mars Hill, North Carolina. (Committed to paper by Fay Coker Walker, Director, Social Work Program, Mars Hill College).

COMMUNITY DEVELOPMENT AND HEALTH CARE: A SMALL TOWN PERSPECTIVE

By:

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The development of small towns and surrounding rural areas as an alternative to living and working in and around massive metropolitan centers presents both opportunity and challenge for those who would give leadership to this movement. These areas, depending on their location, have concerns similar to cities. In general, they are either problems of rapid, uncontrolled development or problems of stagnation and decline. The nature of the challenge in community development in both situations is to create and maintain dynamic, flexible local organizations that can set some goals and mobilize resources within and outside the area to accomplish them. Goals are essential to physical, social, and economic development. They educate, arouse interest, and stimulate action, or support for action.

If we are uncertain as to the goals of development perhaps we can find some direction from Dudley Seers. 1/ "Surely", said Seers, " the values we seek are the necessary conditions for a universally acceptable aim--the realization of the potential of human personality"? His answer was, first, a person must have enough income to cover the basic needs of clothing, footwear, and shelter; second, a job, be it studying, working on a family farm, or self-employed or whatever; third, equality of sexes, race, and opportunity. The point about having a job is that one needs to know he is playing some accepted role in society. "To be chronically unemployed, to be chronically dependent upon another person's productive capacity, even for food, is incompatible with self-respect". The social barriers and inhibitions of an unequal society distort the personalities of those with high incomes no less than of those who are poor. The questions then to ask about a community's development are: "What has been happening to poverty? What has been happening to unemployment? What has been happening to inequality? If all three of these have declined from high levels, then beyond doubt this has been a period of development for the country (or community) concerned". Seer's recognized that the fulfullment of human potential cannot be specified in purely economic terms. Education, health services, citizenship, political stability, freedom of speech, freedom from noise and pollution are likewise universal major aims of human development. We are interested here in the relationship between development and health.

Health and Development

We note that Secretary of Labor, Ray Marshall, when he was Chairman of the Southern Rural Health Conference[2/] analyzed this relationship thus:

> "There are several important relationships between rural development and health care... It is difficult to have a productive population if people have serious physical and mental health problems. What often is attributed to apathy among rural people would, in many cases, more properly be attributed to poor health. Clearly, if we are going to have a productive people, we must first recognize and deal with their health problems.
>
> "Second, the health systems promote development in a number of ways. The expenditure of money to establish health facilities makes it possible to improve the quality of life and not just the delivery of health care. Improvement in the quality of life is, in face, our definition of 'development'. In addition, one of the most important problems in rural development is leadership. The establishment of a health system draws to the area leaders and health professionals, and if the right kind of leadership

> comes in with the health system, community leadership resources can be augmented. The interrelationships are such that once a community learns to deal with health problems, it almost invariably improves its ability to deal with other problems".
>
> "Although not automatic, ...the availability of health care is an important inducement for industry to locate in that area.
>
> "These relationships between health and development also work in reverse. A community is not likely to be able to pay for the delivery of medical care, without broader community and economic development.
>
> "Health (then) is one very important component of development, but other important components include education, employment, income maintanance, housing, antidiscrimination programs and the development of organizations to deal with the problems of rural development."

The creation of locality-based leadership organizations that understand and address the interrelationships among the important dimensions of community development as described by Marshall and Seers is a fundamental challenge. A number of boards and committees with responsibilities for development of either economic, educational and social services do exist in many communities. But their leaders need to work together in some kind of organized manner to identify common goals and issues that can be brought directly to the attention of citizens as well as state and federal policy makers, when necessary. Granting the desirability of local leaders getting together around the several facets of human and community development, the question can be raised is this leadership task (or should it be) the responsibility of local units of government? Local governments (small cities, villages, townships, boroughs, parishes) do have key roles to play in community development. However, because their traditional responsibility may be limited to a few functions within a circumscribed territorial jurisdiction, they are frequently not in recognized positions to convene a broad-based leadership group. Time does not permit a full exploration of this observation. Therefore, I choose to focus my remarks to examining the relationship between local governments and rural health services.

Local Governments and Health Services[**]

In America's past, health care was a purely private arrangement between physician patient, in which no level of government had any concern. People in rural or poverty areas who had no access to a doctor made do with folk medicine or no medicine at all. Many people approached sickness with a fatalism that expected little of the science of medicine.

Much has changed since the early days of this country. Medical care has truly become a right, and the U.S. has committed millions of dollars to medical research and the professional training of medical personnel. With the advances in medical knowledge, people have come to expect that they can have access to the amount and quality of care that medical professionals are now able to offer.

While the quantity and quality of medical care has improved over the years, access to physicians has actually decreased, especially in rural and poverty areas. Some writers argue that the apparent doctor shortage is merely a maldistribution problem, with too many doctors choosing suburban locations, leaving rural areas and the inner city poor to fend for themselves.

[**] July Ogden reviewed the General Municipal law of New York State and amendments to the State Constitution from which some of this section of the paper is based.

Another aggravating factor has been the tendency of young doctors to choose the more glamorous medical specialties for their concentration, rather than choosing to be general practitioners.

Steps to Reverse Trends

In recent years, the speciality in family medicine has been created to revitialize and legitimize the discipline of diagnosing and treating a full range of normal human medical complaints that comprises ninety percent of the conditions first presented for medical attention. In addition, Congress has passed acts to encourage medical schools to expand their enrollments, thus increasing the supply of new physicians. While these steps have certainly been in helpful directions, many American communities still find that they lack the medical personnel to provide the level of health care their residents desire.

Government at the federal, state, and local levels has found it necessary to become involved in health care. Initially, involvement was justified by government's mandate to perserve the public health and welfare. Public health departments on state and local levels worked on problems of sanitation and prevention of epidemics. Public funds were used to sponsor much medical research into the causes of diseases and how they were transmitted. It was not until the relatively recent past, however, that government began getting involved in the actual process of the delivery of health care (especially physicians' services) to the public.

States for many years have regulated the deliverers of health care through licensing provisions which set standards of education and services for health care professionals and also establish equipment, staffing, and procedural requirements for health care institutions.

The post-World War II period brought new problems due to shifts in population, new social attitudes, technological advances, and changes in technique background and economic status of the inhibitants of manucipalities (especially cities), thus creating new and greater demands on local governments for facilities and services. These new demands resulted in new administration and financial burdens which accentuated the need for greater state participation with localities in service programs. The result was major state involvement through supporting services to municipalities in almost every area of public service, especially in programs involved with community growth, development, and adjustment to population changes.

Local government leaders have several options for assisting their communities in developing family health care resources. The combination of a greater-felt need for personal health services in municipalities with the presence of new administrative and financial options for local government provides an excellent opportunity for local governments to aid in the provision of the health care that local residents desire. By active leadership, local governments can have a significant part in deciding what health care options will be available to local citizens, thus allowing decisions affecting community health services to be made in the community where they are utilized, rather than on the state or federal level. This should encourage a more effective tailoring of local services to local needs, while the increased accountability and community involvement should improve the responsiveness of medical care providers to their patients.

In short, local governments generally have a great deal of power to control their own destinies in all areas of municipal governance, including the provision of health services.

There are three main choices for local governments seeking to increase the availability for family medical care in their area. These fall into the categories of personnel recruitment, expansion of existing facilities and services, and utilization of the corporate organizational alternatives available under state law.

Recruitment

Personnel recruitment can take at least five different forms: direct person-by-person recruitment of medical personnel by local governments or local organizations; applying for National Health Service Corps physicians; seeking coalitions with area medical schools; subsidizing the medical education of selected students; and recruiting medical paraprofessionals.

Direct recruitment of medical personnel can be a search for physicians for complete health care teams (e.g., a team might be composed of a doctor, a nurse, a social worker, a medical secretary, and a manager or administrator). Popular forms of recruitment are through advertisements in national media, medical journals, medical society recruitment, and recruiting future physicians while they are still in medical schools. However, the general shortage of family care physicians makes for a very competitive recruiting atmosphere for small, rural communities.

New York State Town Law, for example, allows a town to contract for visiting nursing or public health services, to acquire a building and land for a town medical or dental center, and to contract directly with a doctor to provide physician services to that locality. Two or more localities may contract for the provision of joint services, including medical.

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Another possibility for physician recruiting, and the one we have used in my home community, is applying to the federally-sponsored National Health Service Corps. Communities that can demonstrate a bona-fide need for physicians' services can request that NHSC provide them with a team of doctors who will serve in local communities for a two-year period. Local governments can play a decisive role in setting up and equipping a facility for the doctors to work in, including hiring supporting personnel for the physicians and establishing back-up services with other care providers in the area.

A third possibility is for local governments to seek agreements with area medical schools requesting these schools to furnish fourth year medical students to staff an ambulatory care clinic under physician supervision. Again, local government could assume the responsibility for providing a setting in which educational clinical medicine can be practiced (e.g., by providing a building and recruiting and financially supporting medical personnel to aid the physicians).

Fourth, counties in a number of states have the option of establishing annual awards to state residents to study medicine at U.S. medical schools provided the scholarship holders promise to practice medicine in the granting county for some specified time period. Unfortunately, a number of the counties and medical societies which have sponsored medical students have been disappointed to find that those students preferred to repay the grantors rather than practice medicine in the intended areas. Local governments need to be aware of this risk in considering this option.

The fifth option, that of recruiting medical paraprofessionals, is just beginning to become an important alternative to consider in providing family health care. Local governments need the cooperation of at least one area hospital or physician to bring into the local community either physician's assistants or nurse practitioners. A number of states provide for state registration of these two types of paraprofessionals and allow them to perform medical services under the continuous supervision of a physician (although not necessarily in the physician's physical presence) when those medical services are within the scope of practice of the supervising physician. Physicians may employ and supervise up to two physician's associates and two specialist's assistants in their private practice, and hospitals can employ more than two of each type of paraprofessional as long as they work under the supervision of a physician and within the physician's scope of practice.

Skilled paraprofessionals can serve as very useful extensions of a physician, allowing the doctor and staff to provide health care to a greater number of people than would be possible for the doctor alone.

Expansion of Existing Services

A second important area of options for local governments is the expansion of existing health care programs and facilities. Municipalities can work with the local health department or area hospital to develop plans for expanding the amount of ambulatory care available to the general population; this expansion could occur through increased use of paraprofessionals and/or the establishment of satellite health centers in medically underserved areas of the county or district. Cooperation between municipalities would seem to be especially helpful here, where costs could be shared for providing any building or transportation needed. A combination of state aid, service contracts, and fee-for-service payments by users of the service should allow such expansions of ambulatory care to be fiscally sound.

As noted earlier, one or more municipalities could provide the building, funding, and transportation for a local or area-wide health center to be staffed by community medical professionals and paraprofessionals. This combination of local medical resources in a single center should yield greater efficiency in meeting local health needs, arranging public transportation to the center, and providing economies of scale in buying equipment and supplies and setting up the center. One or more suitable buildings may already exist in the community to be served (e.g. schools, colleges, etc). In this way, the center could achieve the benefit of providing needed services to a local population without a loss of community control over the operation of the center.

Local governments might also build upon the medical services they are already required or encouraged to provide for certain population groups as the base for a further expansion of medical services to the population as a whole. For example, municipalities and local health districts may authorize their officials to accept federal grants-in-aid for extending or improving maternal and child health services, the care and treatment of physically handicapped children, and other public health work. These services, too, could be extended, as in a family health center, to other members of the community who need medical attention. Local governments should not be deterred by the realization that a number of different sources of funds may have to be tapped to provide the health services that local communities desire.

Financing Facilities and/or Programs

The third big area of options for local governments lies in corporate financing alternatives. Money for the planning, construction or renovation of ambulatory health facilities is available where justified under federal programs in H.E.W. and the Farmer's Home Administration in the Department of Agriculture. State sources should also be investigated as well as private foundations for this type of support.

Obstacles to Local Government Involvement in Health

Although local governments, at least in the state with which I am most familiar, have many opportunities and approaches available in their attempts to provide good health care for their communities, there are several obstacles that limit participation. The first is local elected officials' attitudes. Many local governments find assisting with health services to be an area outside the traditional realm of responsibility. The years of expertise that local governments have accumulated are usually more closely related to roads, dumps, water, and sewer systems rather than to the provision of health and social services. Many local leaders are not comfortable with the new social service roles that are being expected of local governments. This barrier is gradually disappearing as decision makers get more experience with revenue sharing and the greater opportunities to participate in community development.

The second obstacle is citizen lack of information. Local citizens, as well as community decision makers, have to come to an understanding of the new local opportunities for health service and other community development projects under revenue-sharing. They need to learn which segment of government has been designated to be responsible for meeting health service needs, and also learn to communicate their views of local priorities and needs to local leaders. A developing public awareness of increased local opportunities to effect and guide community development should increase respect for the tasks of local government and encourage citizens to participate more actively since these local governments will now be making more of the decisions that directly affect the lives of the community residents.

A third obstacle is almost invisible to the public at large. It is generally assumed that restrictive laws keep local governments from doing all they would like toward the provision of adequate health services for their municipalities. However, if New York State law is any indication of what is possible, one finds only broad policy statements and programs designed to increase the supply and availability of local health services. A bottleneck for local plans may be a legal requirement that the locality get administrative approval for its projects, from the State Commissioner of Health, or other state and federal administrative agencies. This is an obstacle that Health Systems Agencies and sub-area councils can assist with. Perhaps the many delays in getting approval for innovative projects are unnecessary and defeat the legislature's actual intent. In any case, it is fruitless to blame the laws for delays due to bureaucratic hang-ups. Technical assistance in preparing proposals and managing even small groups health practices requires administrative skills. Local persons can be trained through C.E.T.A.** or other funds to perform this function for local units of government. In the meantime, municipalities should not be deterred from wider activities in the health care area for fear that they are outside the sanction of law. Local governments must instead put pressure on state and federal agencies to act in accordance with recognized public policy encour-

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** Comprehensive Employment and Training Act ing the greater provision of health care to its residents.

This is an unparalleled time for local governments to take advantage of the alternatives before them to tailor community development projects such as health services to the needs of their local populations.

Overcoming Obstacles--A Case Report

We conclude by briefly describing a four-year old experiment in which the leaders of five small municipalities plus a small private college formed a not-for-profit organization to jointly secure health services for their respective populations. We believe it illustrates a number of points made above. However, as every state and community is unique, the case reported should not be considered "the model" to apply in other situations. Yet, it may suggest some ideas and stimulate a discussion of alternatives suitable to other small towns and rural areas.

Each of the towns and the private college faced a common problem--the need for primary care medical services. A small population base of 8500 between them and limited financial resources suggested to me that it might be worthwhile to convene town and college leaders to consider some form of cooperative effort. All agreed as to the desirability of such a move but no one town or the college felt they were in a position to assume responsibility for organizing and spearheading the effort. After considering several alternatives they decided to form a not-for-profit community development corporation under a section of the state law authorizing such organizations.

The Community Development Federation, Inc. (CDF) as it was named came into existence to sponsor the development of a group medical practice that would provide services to the entire area of around 170 square miles. A Board of Directors with representation from each unit plus other appointed-at-large constitute the policy-making body. As there are a number of technical problems involved in establishing and operating an organization one of the first decisions made by the board was to employ a competent person as administrator. While thaer was some questioning at the outset as to the need for such a position, it has completely disappeared as all members of the Board have come to see the significance of this key role.

The CDF contracted with the National Service Corp for physicians. Both parties recognized this as a temporary arrangement as the CDF assumes responsibility for recruiting permanent medical staff.

The towns and college, in turn, contract with the CDF to recruit and maintain a medical staff that operates on a fee-for-service basis. The CDF also contracts to provide various clinics for public health and social service departments. The college contracts with the CDF for specified facilities in a section of the college infirmary. This facility, located on the edge of the campus, is easily accessible to patients from the community.

The CDF is completing its fourth year and is financially and organiztionally sound according to audits that have been conducted. This is not to say it is without problems with continuity of physicians over the long haul heading the list. Its strength is in the local leadership it is developing. One-half of the 18 member Board has been replaced and the set of officers recently elected are bringing new vigor to the unfinished tasks.

The CDF was incorporated in a way that permits it to sponsor projects other than medical services should problems cutting across town jurisdictions come to its attention. Declining school enrollments with surplus building space, jobs, property tax reassessment, inadequate housing, public transportation, revitilization of a sense of community are some of common problems confronting the area. The Federation concept provides a flexible organizational mechanism for bringing local leaders from several public and private agencies together to consider issues and alternatives. Should joint study or action on a particular problem be indicated, it can be undertaken through the Federation without interfering with the internal affairs of its organization members or threatening their separate identies. Basically, it is very similar to the Community Development Corporation concept. One difference appears to be that the CDF idea envisions a more encompassing examination of the social as well as economic interrelationships that constitute community development. We started with health services as the immediate problem. Another community might decide that housing, education or jobs is a priority problem. The important thing, it seems, is to identify and study the relationships among the several dimensions of community development as proposed independently by Seers and Marshall that we quoted at the outset of our remarks.

The role of local governments in providing health care services needs further study and clarification. They do have an opportunity and obligation to provide leadership even though tradition, state laws, and the private practice of medicine may limit participation. Kane[3/] reminds us of the all-too- familiar problem in rural areas where a community served by a single, elderly physician is unsupportive and the community gives up for fear of alienating or losing its one assumed but inadequate source. "If rural health care is to make any significant progress", writes Kane, "this pattern must be changed." Local government has the capacity to provide the necessary leadership to encourage a more long-term view...the willingness of communities to pool their resources requires a substantial degree of insight and maturity on the part of the government and the electorate. Local officials who have the trust of their constituents and who understand their concerns must be able to articulate and sell a plan whereby the needs of the community will be better served by partially owning a larger enterprise than by solely sponsoring an inadequate whole". The community Development Federation concept may be the type of loose organizational structure that helps overcome historical inter-community rivalries without threatening local identifications with a particular name place.

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RURAL COMMUNITY DEVELOPMENT

By:

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Office of Human Development
Atlanta, Georgia

For a long time, Americans have been concerned about rural community development and organization of community resources, both human and material resources, to help eliminate problems of poverty often experienced in the midst of national well-being and prosperity.

My response here today will be centered around my experience as a rural county agricultural agent, and a combination rural/urban area community action leader and director, first as County Agent in West Georgia, Mariweather County, working under a rural community development grant with a major responsibility for organizing over eleven hundred junior, senior, and Clover Leaf 4-H Club members, leaders, and parents into eight major 4-H Clubs, training individuals and groups to participate in county, district, and state activities and projects contests. Seven years were then spent in Morgan County, Madison, Georgia, organizing 4-H 'er civic leaders, and farm families for community action activities and rural development.

Second, I served as President, and Executive Director of Action, Inc. , a large community action agency with 147 full-time staff members and part-time CETA (Concentrated Employment Training Act) employees numbering over 1,200 during summer months carrying out community action projects in 16 counties in Northeast Georgia.

Over the years, a number of major efforts have been launched to meet and overcome the problems of the poor in rural areas. Community organization is one of these major efforts I have experienced, and have had some success. These efforts have ranged from private efforts to promote human welfare, to the concentration of programs supported by county, state, and federal government partnership, in cooperative programs to combat poverty and develop community resources.

Organized community group activity is an important way of pulling together a local coalition against the causes of poverty in rural communities. It is a way for local citizens to participate and it provides an opportunity for community in-put for purposes of improving and enriching the lives of all citizens.

Community action is a process which aids in developing lines of communication between all segments of the community, i.e., between poor and non-poor, between government officials and private organizations, and between public and private agencies which operate programs. Most important, community groups build bridges between one poor person and another. This enables each individual to share in the dignity of self-help and escape from poverty.

Community organization is really a way of mobilizing resources of all kinds to create better conditions for local citizens. Community organization focuses attention on planning and implementing action at the community level.

A community organization can exert its influences and can stimulate local, state, private, and federal resources to aid low-income families and individuals, of all ages, in rural and urban communities. In addition, community organization can engender the skills, knowledge and motivation necessary for individuals to become fully self-sufficient.

The problems of poverty are a network of social ills, such as unemployment, illiteracy, and poor health, especially in rural areas, To alleviate these ills requires collective effort, talent, and leadership in the community.

In organizing a community, it is important for a leader to consider prior experiences and activities. It is especially necessary, judging from past experiences, that the community organization see its principle role as mobilizing community resources rather than authorizing activities. Leaders must inspire and stimulate action, employing many approaches for treatment.

The task of the community organization can be thought of in terms of four major goals:

--Coordination and development of services
--Involvement of the people who need help
--Stimulation for change
--Mobilization of the community

A major goal can be to coordinate the activities of various agencies so as to increase the total impact of all efforts. It can mean the development of policies and programs for purposes of expanding and making services more available.

The second major goal can be to assure the maximum participation of the residents of the area to be served, in policy development, in program planning and development, and in operations.

Third, there is little chance for a successful community organization unless the participating individuals not only work together but also welcome the opportunity to improve internal operations and to change. Responsible efforts must be made to generate new ideas and to challenge old assumptions about services and the nature of the problems of the local communities.

The final goal could be the full mobilization of the resources of the community. Such mobilization may take months or years, but there must be evidence of continuous progress. It requires planned methods of increasing public awareness of the problems and issues as well as specific efforts to enlist services from the social, educational, religious, governmental, civic, and economic leaders and organizations.

"HUMAN SERVICE NEEDS IN RURAL TENNESSEE: A CASE STUDY"

By:

Joylean P. Sampson, MSW
Principle Investigator
Tennessee State University

Introduction

The focus of this paper is directed toward a brief discussion of the identified needs of isolated rural dwellers in areas of Davidson, Williamson, Rutherford, and Cheatham Cheatham Couties in Tennessee. Davidson County, like the other counties studied, covers large acreage of square miles. A large part of Davidson, Williamson, Rutherford, and Cheatham Counties are sparsely populated, engaged in agricultural pursuits, and live an essentially rural way of life. Others commute to "the city" from a farm or a rural community to work in business and industry or to obtain services such as medical care. Few services are physically based on these outlying areas because of such consideration as the economy and the emphasis placed on "inner city" problems. A number of very isolated communities exist in the counties selected for study. Those communities are: Four Corners, New Hope, Christiana, Scottsboro, and Pasquo. Some of these communities are considerable distance from major services ranging from 13 to 25 miles while others tend to be isolated because of cultural or racial factors. Some of these communities are hidden and unknown by the general population and from all but the most knowledgeable service workers. The objective of this paper is to describe the social and health needs while determining the demographic characteristics of people residing in those selected rural areas of isolation. It should be emphasized at the outset that we are reporting findings from one phase (consumer phase) of the research report. The reader should keep in mind that the findings reported herein are based upon the consumer information alone, and that the brief analysis provided is made from this data and not the total study.

Methodology

Subjects and Sampling Procedures

Analyses of differential services to clients as well as geographical areas were based on the following criteria:

(1) Physical accessibility to the Nashville area;
(2) The extent of sparsely population-density of poor-population of 7,000 or less;
(3) Accessibility to health and social services;
(4) Racial characteristics;
(5) Housing characteristics;
(6) Limited employment opportunities;
(7) Isolation and undeveloped territory of 1,000 or more acreage;
(8) A continuation of severe economic and social deprivation.

Other criteria included common culture and common patterns of social and economic relation. Careful analyzation of census and historical documents were reviewed so that areas could be selected. The results of the utilization of these criteria yielded the selection of the following counties and communities: (See Figure I- Map of Geographical Area)

(1) Davidson County: (a) Four Corners Community, (b) Scottsboro/New Hope Communities, (c) Pasquo communities,

(2) Williamson County: (a) Fairview, (b) Kingfield Communities,

(3) Rutherford County: (a) Christiana Community, and

(4) Cheatham County: (a) Bell Town/Pegram Communities.

A simple random sampling technique was used for the selection of the cases studied. Highway maps locating roads and households for each isolated geopraphical area in each county were used. Each of the isolated areas was marked as segments. The total number of elements in the study population was 854 units. A sampling proportion of 50% or every other household was selected for interviews (427). There were 321 subjects who accepted interviews from the four counties which constituted the study population.

The Method of Gathering Data

Indirect observation was utilized in this study. Among the many methods available which would facilitate indirect observation, the interviewer administered questionnaire seemed most suitable. The consumer questionnaire was developed for purposes of obtaining:

(1) Demographic information, i.e., socio-economic data (income, occupation, etc.), socio-demographic data (age, sex, race, education, etc.),

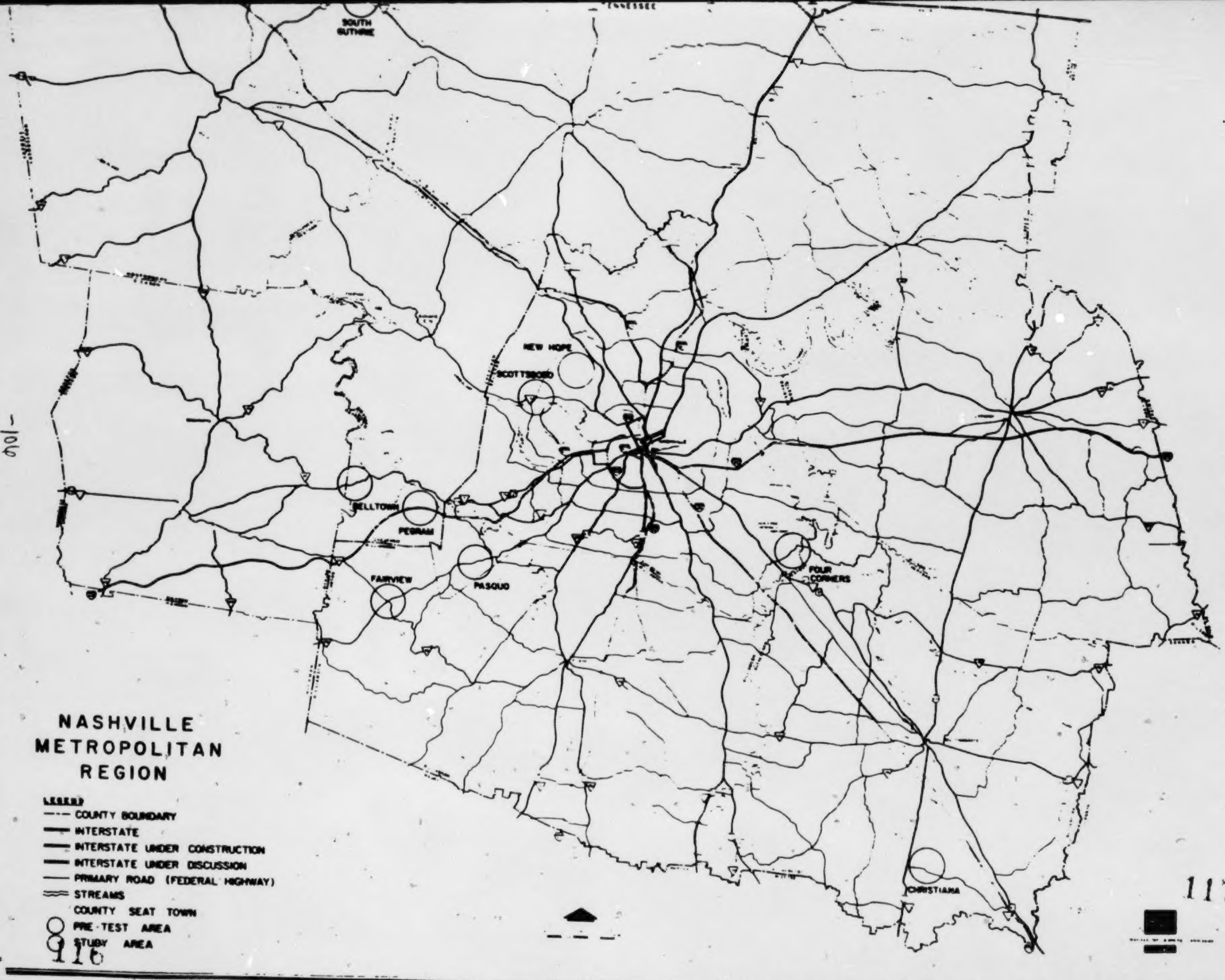

TENNESSEE
SOUTH GUTHRIE
NEW HOPE
SCOTTSBORO
BELLTOWN
PEGRAM
FAIRVIEW
PASQUO
FOUR CORNERS
CHRISTIANA
NASHVILLE
METROPOLITAN
REGION
LEGEND
COUNTY BOUNDARY
INTERSTATE
INTERSTATE UNDER CONSTRUCTION
INTERSTATE UNDER DISCUSSION
PRIMARY ROAD (FEDERAL HIGHWAY)
STREAMS
COUNTY SEAT TOWN
PRE-TEST AREA
STUDY AREA

FIGURE I- MAP OF TARGET AREAS STUDIED

(2) Environmental information (housing, garbage, heating, sewerage conditions, and

(3) Information pertaining to, (a) the accessibility of health and social services, (b) the rate of consumer participation and degree of satisfaction with services, and (c) the assessment of community and family needs.

Findings

Demographic Profile

The study population may be described in the following manner: twenty-three percent or (75) were males and seventy-six percent or (244) were females. More than 1/3 of the study population were of the 50-65 and older age range, married couples with approximately 50% of the respondents receiving eight or more years of schooling. The majority of the respondents indicated an affiliation with the protestant religion. Sixty-eight (68%) of the respondents indicated a preference for the democratic party; and the remaining 15% were Republicans. Almost 1/3 (31%) of the study population were household workers while 22% were farmers. Twenty-two percent of the population earned less than $6,000 gross income per year while 31% of the respondents earned from $6,000 to $11,000 gross income per year. Seventeen percent earned $12,000-$13,999 gross income per year. The remaining household incomes were distributed in small percentages throughout other income ranges. The following figures provide an indept profile of demographic features of the sample:

Figure 1

Sex, Race, Marital Status, Age and Education

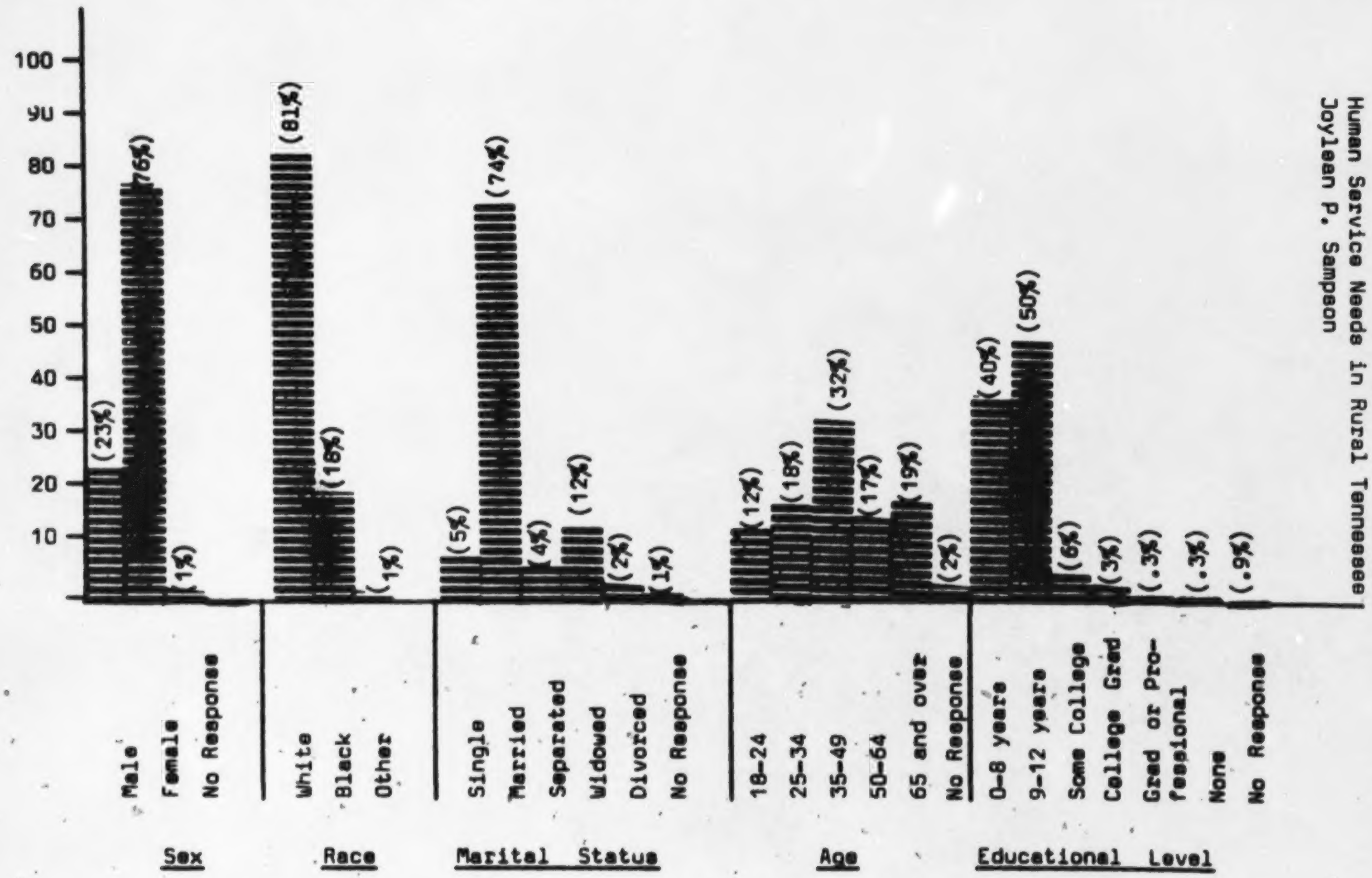


Figure 2

Religion, Political Preference, Occupation

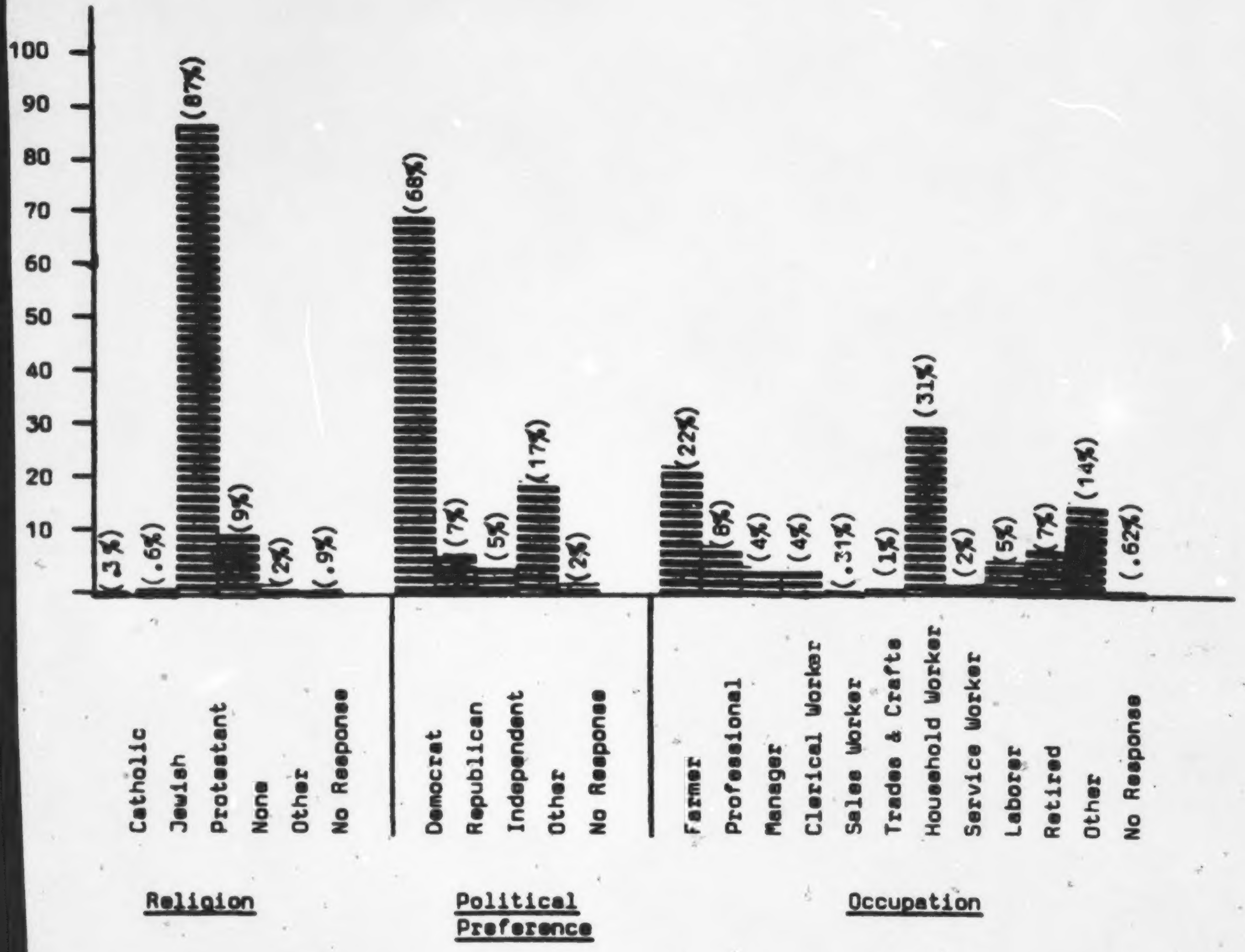


Figure 3
Income Level

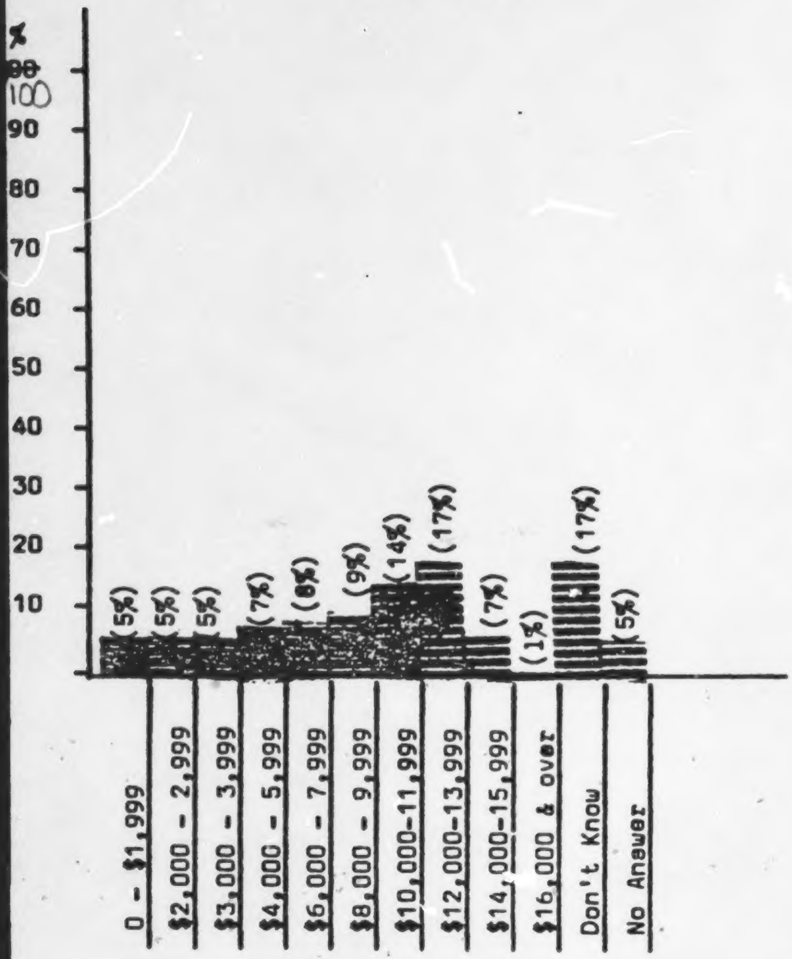
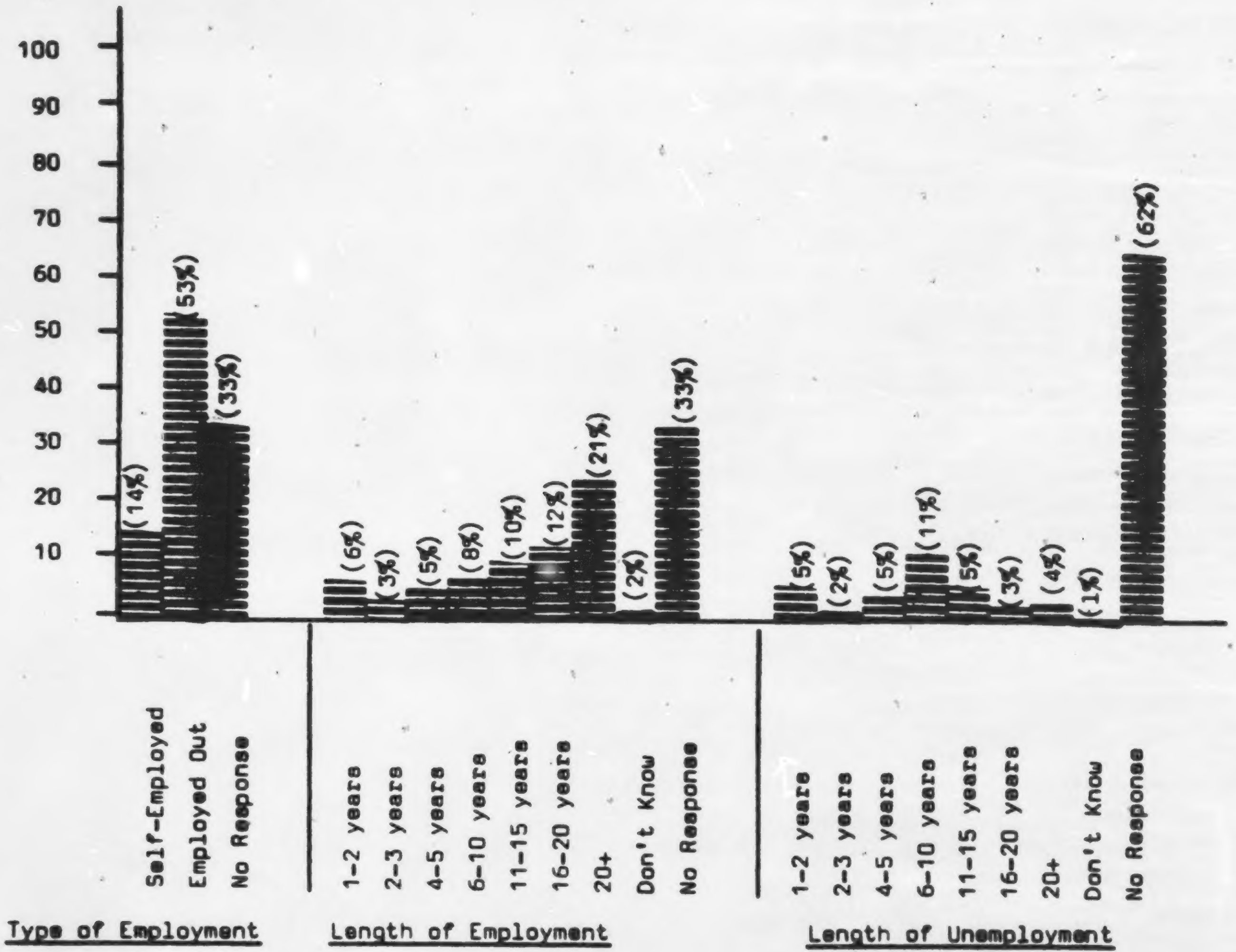


Figure 4
Type of Employment, Length of Employment, and Length of Unemployment



Human Service Needs in Rural Tennessee: A Case Study
Joylean P. Sampson, MSW

Community and Family Needs

The study of rural society is a practical as well as a scientific pursuit. It supplies knowledge of the importance of rural America and of rural-urban relationships. According to Brunner and Kolb[1] the study of rural society furnishes techniques and clues for the understanding of rural life and the problems faced by rural families and communities. By studying the six communities in Tennessee, it was assumed that some determinations could be made about their customs, problems, and needs. Assuming that needs are determined by what that community perceives as needs.

To speak of needs assessment implies that people's needs change and what may be perceived as a need in one time frame may be totally different in another. This research project was interested in the respondents' assessment of needs in their communities. They were asked to identify the greatest needs in their families and communities and rank them according to priority. The needs identified in the total sample were ranked as follows:

COMMUNITY NEEDS	RANK	%
Medical Services	1	57.3
Public Transportation	2	25.9
Improved Housing	3	21.8
Day Care Facilities	4	20.2
Improved Roads	4	20.2
Social Services	5	18.6
Employment Services	5	18.6
Legal Services	6	8.7
Fire Protection	7	5.9
Recreation Facilities	8	4.9
Police Protection	9	3.4

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[1] Brunner, Edmund and John D. Kolb. A Study of Rural Society. Connecticut: Greenwood Press Publishers, 1971.

Family needs were also ranked:

FAMILY NEEDS	RANK	%
Utility Services	1	12.8
Baby Sitting Services	2	6.5
Medical Services	3	5.6
Money	4	3.1
Transportation Services	5	1.9

In identifying family and community needs, the list reflects those services that are absent from the community or too far away. Therefore, need is being defined by the consumer or respondents to be the lack of those social public, and health service agencies that would improve the quality of living in rural communities and families.

Family and community needs were also crossed-tabulated with each geographical region to show individual county ranking of needs. Family and community needs were listed as follows:

FAMILY AND COMMUNITY NEEDS BY COUNTY

DAVIDSON COUNTY	#	%	RANK
Medical Services	72	48	1
Public Transportation	54	36	2
Improved Housing	34	23	3
Social Services	26	17	4
Improved Roads	24	16	5
Day Care Facilities	21	14	6
Fire Protection	16	11	7
Employment Services	15	10	8
Police Protection	10	7	9
Recreation Facilities	9	6	10
Legal Services	9	6	10

FAMILY	#	%	RANK
Utility Services	44	29	1
Transportation Services	8	5	2
Medical Services	7	5	3
Money	4	3	4

WILLIAMSON COUNTY	#	%	RANK
Medical Services	69	71	1
Day Care Facilities	42	43	2
Improved Housing	19	20	3
Employment Services	19	18	3
Public Transportation	18	19	4
Legal Services	18	19	4
Social Services	17	17.5	5
Improved Roads	11	11	6
Recreation Facilities	5	5	7
Fire Protection	3	3	8
Police Protection	3	3	8

FAMILY	#	%	RANK
Baby Sitting Services	14	14	1
Medical Services	13	13	2
Money	8	8	3
Utility Services	4	4	4
Transportation Services	1	1	5

RUTHERFORD COUNTY	#	%	RANK
Employment Services	26	68.4	1
Medical Services	25	65.8	2
Improved Roads	16	42.1	3
Improved Housing	15	39.5	4
Social Services	13	34.2	5
Public Transportation	4	10.5	6
Day Care Facilities	1	2.6	7
Recreation Facilities	1	2.6	7

FAMILY	#	%	RANK
Money	7	18.4	1
Medical Services	5	13.2	2

CHEATHAM COUNTY	#	%	RANK
Medical Services	18	50	1
Improved Roads	14	38.9	2
Public Transportation	7	19.4	3
Social Services	4	11.1	4
Improved Housing	2	5.6	5
Day Care Facilities	1	2.8	6
Legal Services	1	2.8	6
Recreational Facilities	1	2.8	6

FAMILY	#	%	RANK
Utility Services	4	11.1	1
BabySitting Services	2	5.6	2
Money	2	5.6	2
Transportation	1	2.8	3

The need for medical services ranked number one in priority with 57% of the respondents feeling the need for medical services in their communities. This expression of need was consistant with the fact that respondents (67%) were dissatisfied with the availability of services. They attributed the medical need to inadequate medical facilities and felt the medical facilities were too far away.

Public transportation also ranked high in priority of needs. The respondents did not use public transportation because it was not available in their communities. Those respondents who did not own vehicles were provided transportation by relatives, friends, and neighbors.

It was ironic that money was not a high priority need (31%) assuming that money could provide for better medical care as well as bring doctors into the rural communities. Further analyses revealed that money ranked higher in Rutherford County as a family need than the other three counties. One would think that Cheatham County respondents would have ranked money higher, based on the present economic conditions of the county and the need for increased financial resources.

As far as the relationship between the utilization of services and the need for services, 82% of all respondents did not utilize hospitals and 82% did not utilize the Health Department. These percentages reflect the fact that services are not convenient to the community. Therefore, the community perceived medical services as a community need as well as a family need. In several cases family and community needs overlapped.

The need for money, medical, transportation, and day care were identified as family and community needs. Of the needs identified, only the need for medical services was identified by greater than 50% of the respondents. Other needs were identified by an average of 14% of the total sample.

Summary

A questionnaire was designed and administered to a 50% sampling proportion (simple random sample) of households in four Tennessee counties. While it is perhaps too early to draw conclusions at the time, careful analyses of the findings may be summarized as follows:

(1) The absence of medical facilities, physicians, and social services in the counties studied has resulted in respondents having to travel greater distances (13 to 25 miles) to secure these services. This means that the average citizen residing in Cheatham, Williamson, and Rutherford Counties must travel greater distances for specialized social and medical services.

(2) The need for money, medical, transportation, and day care were identified as family and community needs. The need for medical services was identified by greater than 50% of the respondents. Consequently, medical services unquestionably ranked number one as the greatest need in all counties except one.

(3) The study population may be described as follows: the majority of study population were female, older married couples with 12 years or less of schooling and with occupations of farmers and household workers.

REVIEWER'S NOTES

A REVIEW OF SESSION ON " RURAL COMMUNITY ORGANIZATION AND DEVELOPMENT"

By:

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Assistant Professor
Sociology Department
Tennessee State University

This critique will summarize the contributions made by each panelist and then synthesize their respective inputs into a systems model. It is hoped that the model will be of some utility for analyzing the patterns of rural community organization and development.

Ms. Marie Cirillo, Rural America Inc., indicated that she was employed by a church organization and that it was from this base that she moved into the Appalachian community. According to Ms. Cirillo, the real purpose of community organization is two-fold: (1) clout or power to shake-up government agencies and (2) clout or power to deal with the large corporations. Ms. Cirillo drew a distinction between organization and development. For her, development was characterized by programs designed to create self-help, creativity and new programs in the hands of the people. She identified the major problems of the rural citizen as housing, jobs, and services. In order to combat the encroachment of big corporations, rural Americans must own land and the instruments of production. She was pessimistic about the merits of full employment as a viable solution because of the impact of big corporations. For sociological purposes, it appears that her analysis was guided by a conflict model of society. Thus the goal of community organization is to challenge the big corporations and to influence governmental policies relevant to the social conditions of rural Americans.

Mr. Simpson J. Clark, Office of Human Development, HEW, explained that his job description entailed helping vulnerable Americans such as the aged, the youth, the handicapped, et.al. From his experiences with government bureaucracy it seems as though the purpose of helping people has been abandoned for the purposes of process and guidelines. In layman jargon, asserted Mr. Clark, "the red tape," a reality in the Americans society is social inequality. According to Mr. Clark, this proposition must be accepted if one is to realistically address the problems of the rural citizen. This social reality was illustrated by a passage from Victor Hugo and a folk tale about the unemployed rooster. In terms of community action, it was Mr. Clark's feelings that one cannot solve the problems of the rural poor and maintain his job at the same time. The community activist is torn between the demands of the community people and the power structure. It is impossible to satisfy both interest groups. In terms of step by step procedures, Mr. Clark felt that the best season for community organization in the rural community is during the Fall. During the Spring and Summer months the farmers are too busy with planting and collecting the harvest. It appears that Mr. Clark's analysis was guided by the philosophy of realism. Through trial and error Mr. Clark learned that the interest of the rural poor and the interest of the power structure are often in conflict.

Mr. Gary Smith, ACSW, Asst. Professor of Sociology and Anthropology and Social Work, suggested that the key questions in the study and practice of community organization come under the categories of awareness, interest and identification of leadership. As a sociologist, he observed that there is often variance between knowledge about community people gained from research and the actual social facts that reflect the daily realities of the community. His key analytical concept was developmental socialization. This concept is useful for the purpose of understanding the socialization process of adults. He suggested that this concept had three dimensions: cognitive, affective, and the socio-cultural environment. As we observe the shifts from childhood socialization to adult socialization, the following patterns emerge:

	Childhood	Adult
1.	concern with motives and values	concern with overt behavior
2.	gaining new knowledge	synthesis and reorganization of old knowledge
3.	idealism	realism
4.	teaching and learning expectations	how to mediate conflict
5.	general demands of society	specific role expectation

None of the speakers addressed the issues of collective barganing, labor unions, and negotiations. These are crucial issues due to the fact that farming is rapidly becoming an industrialized process.

In formulating a system model for community organization and development, the concept of community must be viewed as the basic unit of analysis. Frederick Bates defined a community as "a social system whose funtion is to manage conflict and competition so that the separate and specialized interests that comprise the community can exchange outputs and obtain from each other the inputs they need for survival." It was suggested by two of the speakers that the interests of the community and the power structure are often in conflict. Thus the model must be able to respond to conflict as well as cooperation. It was further felt that the leadership must be a process of influence. This influence should be a reciprocal exchange between the aspirations and the interests of the rural community and the knowledge and skills of the leadership. The leadership cannot dictate the definition of goals and problems to the community. These definitions must surface in a division of labor between the community and the leadership.

Dr. Andrew J. Jackson
Community Organization
and Development

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A REVIEW OF SESSION ON
SIMULATED MODELS FOR RURAL SOCIAL SERVICE DELIVERY

By:
Celeste G. Simpkins
Research Associate, Center for Community Studies, George Peabody College for Teachers

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This session was very lively and informative: balancing the technology of rural service delivery with the human concerns which must be understood and taken into account if one is to deliver services to rural populations.

First we heard from Dr. Harold Holder, from the Institute on Human Ecology, Raleigh, North Carolina. Based on his eight years of experience in modeling and aiding agencies in operationalizing the models, Dr. Holder presented the basic components needed in building a model for a rural service delivery system, or any service delivery system. The model, as he explained it, is predicated on the following:

--At any point in time there is a subgroup of the population with some level of unmet needs. The task is to keep this subgroup as small as possible.

--This can be done by either moving people or preventing the need, or some combination of both.

Within any given community there is a number of functioning support systems: family, education, health, etc. Unmet needs occur when there is failure to get needs met within existing systems. A problem is how to back up the primary systems already in place and get the individual with needs to the correct service agency. On the one hand, there is the individual with needs and, on the other hand, a number of agencies and providers. How is an individual to connect with the correct provider?

According to Dr. Holder, five components must be in place in order to have a viable working system:

1. There must be a community or populace, presumably with some degree of unmet needs.

2. There must be a governance body. Frequently governance is comprised of elected officials, though this does not have to be the case. These are the persons who are in a position to hear of the needs and respond.

3. There must be a specification of the service to be performed.

4. There must be a system manager who is accountable to the system and is held responsible for the client.

5. There must be the service delivery system.

There also should be a performance audit by an independent person to inform the system's manager and to feedback to the community information on how well the system is performing. Dr. Holder suggested that this audit should be presented to the community (i.e., published in a local newspaper).

In the optimal delivery of services, accountability also must be included inside the service delivery system. One option is to assume the client knows his/her need and to hold the client responsible for contacting the provider that can meet this need. However, if a client has multiple needs, no one provider is accountable to see that this person has all of his/her needs met. A second option is to include a case manager within the delivery system who would serve as an ombudsman/liaison function--representing the system and being accountable for the whole person. The case manager would act as a contracting agent and, ideally, have resources to purchase the services needed for the client. (I suspect that in reality the case manager would usually serve as a referral agent.) But ideally the case manager would have the power of purchase and could focus on those agencies that perchase and could focus on those agencies that perform well in meeting clients' needs. A competitive market would presumably bring about improvement in services delivered.

After outlining these components to a model system of service delivery, Dr. Holder related four service delivery systems in which he had been instrumental in implementing. For three of these four systems, the importance of a lay board and governance by community residents was emphasized.

While this presentation was very interesting and seemed very complete in considering the complexities of designing a delivery system to meet the expressed needs of a community or populace, it did not address a very real problem of many service delivery systems: that is, at the grass roots level, how is contact made with the individual prospective client with unmet needs? Said another way, how does a prospective client decide to avail him/herself of specific services? Or why does one not make use of services when a need is evident and a service to meet that need is available?

Some of these probelms were addressed briefly by Dr. Bonovich, Professor of the University of Tennessee School of Social Work, Nashville, Tennessee. He indicated that social work education has been neglectful in preparing social workers for rural areas because the education is based on the needs of urban areas. However, service delivery programs available in urban areas do not often lend themselves to rural adaptation. Dr. Bonovich stated the need for social work to return to the concept of the caseworker as an advocate, where one caseworker would follow through from need identification to need satisfaction. This concept is much the same as the case manager approach referred to in Dr. Holder's model of service delivery. The caseworker-advocate approach would require that social work education move away from specialization and toward a general practitioner model. Dr. Bonovich concluded by asking service deliverers and social workers to have input into the educational system to help guide educators toward more appropriate and useful curricula for social work education.

The final speaker for this workshop, Ms. Faye Walker, Director, Social Welfare Department, Mars Hill College, North Carolina, brought the session into sharp focus, viewing the problems of service delivery first from the rural Appalachia consumers' perspective, then from the perspective of the social welfare providers and social workers. Ms. Walker colorfully and poignantly described the sub-culture of rural Appalachia in terms of its strengths, which are also its weaknesses: the prideful independence, strong friendship and kinship networks, and its ties to the land. While Ms. Walker was speaking specifically from her experiences in rural Appalachia, this reviewer felt that much of the subculture she described is evident in any low-income, rural area and is not an Appalachian idiosyncracy. For instance, Ms. Walker spoke on the following points: In the past, the land provided what was needed (food, clothing, shelter) and the family and its kinship and friendship networks were the support systems. Reliance on families and community members was once a necessity because of geographical factors and obstructions (distance, bad weather, impassible roads, absence of transportation, etc.) The people of Appalachia thus developed little need or experience in getting "outside" help. These statements seem equally applicable to most rural areas.

Celeste G. Simpkins
Review Session III.

After describing the subculture of rural Appalachia, Ms. Walker turned to an historical description of social welfare in general, and the current problems encountered in delivering services in rural Appalachia in particular. Ms. Walker reiterated many of the points covered by Dr. Bonovich: the fact that social welfare grew up in urban areas, is taught using urban models, that rural areas get a much smaller proportion of services than do urban areas, and current centralized delivery systems are inadequate for rural needs.

The importance of understanding, regard, and mutual trust was a constant theme of Ms. Walker's presentation. The "outsider" social workers may not succeed within such an area as rural Appalachia because they may not understand the values of these people and often are not trusted or accepted by them. Natives of Appalachia who are employed in service delivery positions have more experience and knowledge of the population, and this often enhances delivery of services. But as such employees usually are a part of the existing kinship/friendship networks this may create problems of confidentiality. She also emphasized that the manner in which help is offered dictates whether service will be accepted with dignity--rural persons do not receive help, they exchange services. She concluded her presentation with some suggestions for improvement in delivery of services: continuous training of workers, initiating cooperation among service agencies, decentralization of services, making use of existing community facilities such as the local schools for service delivery points, and providing generalized (not specialized) social work.

Simulated Models for Rural Service Delivery
Celeste Simpkins

Following these presentations, there was an open discussion among participants and the audience. These discussions mainly centered on how service delivery providers can initiate community/consumer participation at a "grass roots" level and how to identify the unmet needs of a community. It was suggested that conferences such as this should be built on real issues from consumers, not theories. A paradox of this session, and the entire conference, was that there was no input from consumers, while each presenter stressed the importance of such input. A final, unifying suggestion from each of the participants was the need for generalized social work as opposed to specialized work in rural areas.

A REVIEW OF SESSION ON "HEALTH SERVICES MODELS"

By:

Leslie A. Falk, M.D.
Professor and Chairman
Department of Family and Community Health
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Session III, "Health Services Models," was an interesting and informative session lending support to alternative methods of health delivery of services. The panelists emphasized the need for civilian control and consumer involvement in policy making. The definitions of Health Services Models given were in terms of Health Status and of Health Services.

Unmet health needs studies have been conducted for four decades. Among the rural health survey instruments are those of Horace Hamilton, Selz Majo, Frederick Hofer and others. The panel agreed that preventive measures should be of primary concern. The preventive activities discussed included the following:

(1) Improving health education, self-help, personal hygiene, and life-styles.

(2) Increasing the total supply of physicians in rural areas.

(3) Providing more generalized health services via the Rural Health Services Corp.

(4) Planning and developing future rural health resources via Health Systems Agencies.

(5) Developing alternative methods of health care delivery i.e. rural health initiative programs, consumer sponsored health activities, and support of community health centers.

In addition, this session focused on the communities role and the health care delivery system. There was emphasis on:

(1) Community needs assessment for the purpose of understanding rural health problems.

(2) Identifying the real service market.

(3) Reviewing other health care models in other states.

(4) Evaluating the opinions of local people, including health professionals, consumer and public officials.

(5) Providing opportunity for consumer input and recommendations for changes in the health delivery system.

The panel then discussed the federal government's involvement in rural health services, e.g., the Health Resources Administration, Department of Health Education and Welfare. It was recommended that the rural health care systems linkage to the federal government provide a complete range of services. Those services include:

(1) An area wide definition of service area
(2) Financial commitment
(3) School and community health programs.

Medical school involvement in rural health models was recommended, including family practice training, nurse practitioner education, physician assistants, and management education (health administration).

The panel felt primary care is the way to unify preventive and curative medicine. Local self-sufficiency is impossible. Communities must help each other in larger units and there must be an outward flow of consultation and education to the smallest communities.

A Review of Session on Policy Making and Funding

By:

Charles Sampson Ph.D.
Associate Professor and
Chairman of the Department of
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This review provides a summary of the session on policymaking and funding, moderated by Dr. Paul Taylor and staffed by practitioners and academicians alike.

One of the panelists presented information relative to new technology designed to increase the quality of rural life by providing a list of varied federal programs relative to the same. It was described as a computer assisted program which could be accessed by a portable terminal, connected via telephones and is referred to as the Federal Assistance Programs Retrieval System (FAPRS). This system identifies federal programs that can be used to meet the development needs of any community. It is designed primarily to identify only those programs funded during the current fiscal year, and for which the community meets the basic eligibility requirements. In effect, a clearinghouse of rural programs could become available to subnational public agencies as well as to private concerns associated with the delivery of selected services to rural America.

In another area, the question of health care spending was addressed. It was observed that the government's role represents up to 40% of the cost of health care to rural residents. Never-the-less, the panelist reported that "out- of - pocket" expenses for health care continues to increase. The panelist further observed that the reason for increased governmental involvement in health care maintenance is due to an effort to redistribute income and to increase benefit spillover from urban to rural residents. The panelist further suggested that rural area residents may not be getting their fair share of the health care dollar. In supporting that contention, he noted that 1) medicare reimbursement in rural areas is roughly one-half that of the urban areas, and 2) the per capita expenditures for county population is significantly lower than for urban areas. The alternative that could be embraced at the federal level is to 1) extend medicare coverage to reimburse clinics in medically underserved areas where physicians are unavailable, 2) base access to medical reimbursement on need, 3) reduce the number of prevailing charge localities, and 4) encourage local government financing of health care expenditures.

Finally, the third panelist suggests that rural health and other services cannot be planned or evaluated on a comprehensive holistic basis. The panelist suggested that a fragmented, incremental unplanned approach to service delivery and assessment capabilities is more meaningful than a meticulous front-end approach. The panelist reasoned that the science of muddling through has greater virture due to its greater flexibility to adjust unpredicted and unpredictable variables.

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